# CHEMIST & DRUGGIST

THE NEWSWEEKLY FOR PHARMACY

5 July 1997




## Health Action Zones include pharmacists

## Doctor dispensing – 'judgment reserved'

## Pharmacy fear as super-surgery gets go-ahead

## Repeat dispensing: who is piloting what ...

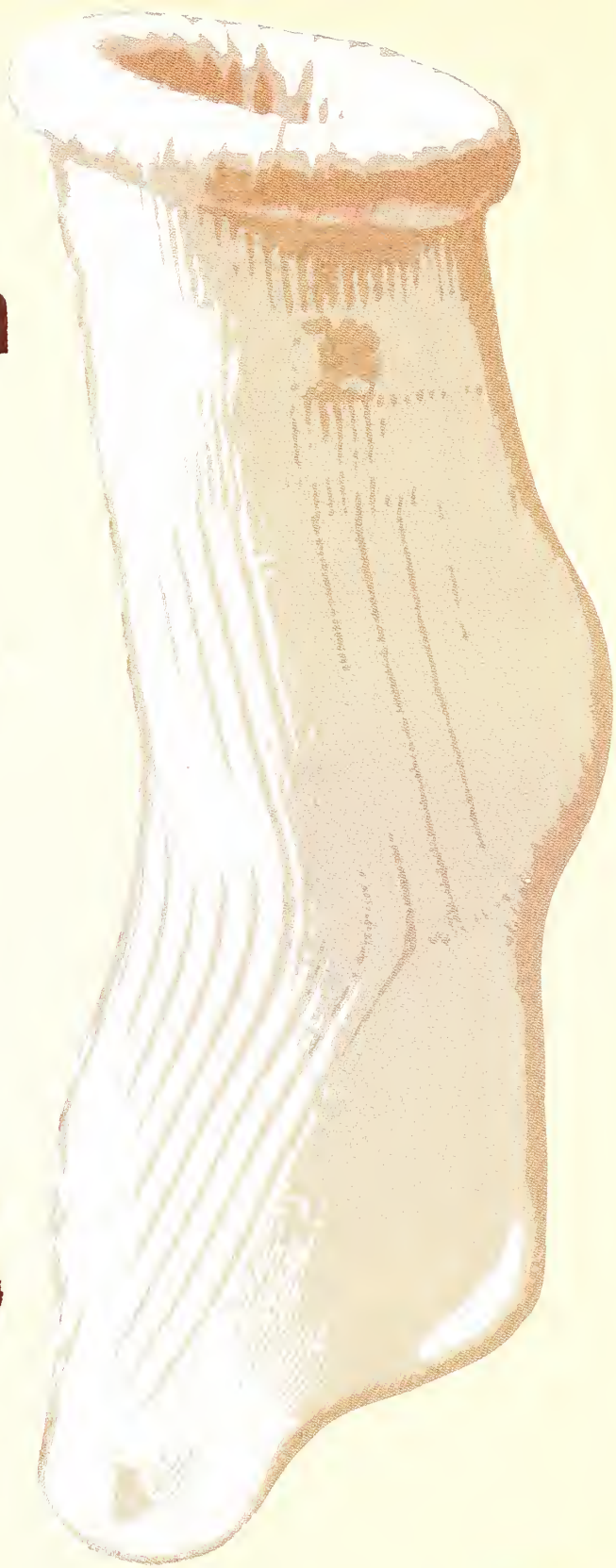
## Update: no longer a disease for 'old ladies'

## Stress specialist urges help for pharmacists

## Amersham and Nycomed form £1.8 billion group


Online at http://www.dotpharmacy.com/

# Pharmacists of Great Britain join the campaign for Safe Socks




**Help is at hand for the nation's sweaty feet. It's new Driclor Powder, the latest addition to the Driclor clinical antiperspirant range. Thanks to a clever micro cellulose formula, Driclor Powder absorbs sweat and cuts off the cause of odour without the usual powder problem of caking. And as if that wasn't enough, it also helps to prevent athletes foot.**

**£½M Summer spend on Driclor Powder and Driclor Solution**

**Presentation.** Powder. **Active Ingredients:** Aldioxa 0.22% w/w, Chloroxylenol BPC 0.5% w/w. **Uses:** Driclor Powder is especially suitable for the feet. It absorbs excess moisture, has antifungal and antibacterial properties, and soothes inflammation in other skin fold areas. **Dosage and administration:** Dry and apply over feet and other affected skin fold areas. Use on children under supervision. Store in a cool dry place. **Contraindications, warnings etc.** Avoid contact with eyes and broken skin, avoid inhalation. There are no restrictions on the use of Driclor during pregnancy or lactation. Avoid contact with clothing and polished metal surfaces. **Product Licence Number:** 0174/5015R. **Pack size and Retail Selling price:** 50g pack £3.79. **Legal category:** P. **Date of preparation:** April 1997. Stiefel Laboratories (UK) Ltd, Holtspur Lane, Wooburn Green, High Wycombe, Bucks, HP10 0AU.

STIEFEL

## COMMENT

Pharmacists are suffering from high stress levels, to the extent that 59 per cent of those sampled in a recent survey (see p24) would not train as a pharmacist if given a second chance. Not a healthy sign. The ways that stress can damage a pharmacist's ability 'to do the job' are also spelt out and will strike a familiar chord. Change is a typical contributor to stress, and pharmacists have been facing up to a lot of that recently, and will continue to do so. The NPA is concerned that its members are finding it increasingly difficult to fill job vacancies (p20), and part of the reason why can be seen in the results of the survey. The NPA makes the obvious point that despite a steady increase in the number of pharmacists on the Register, many are deciding against a career in community pharmacy. There are other contributory factors, of course, but at a time when the opportunities in primary care (such as repeat dispensing, see p22) are greater than for many years, the manpower shortage is an extremely worrying development. Without motivated pharmacists on the ground to exploit the openings, others groups may well fill the breach. The NPA "strongly suspects" that the low salaries paid to pharmacists as a result of an underfunded service are a significant factor in the manpower equation. In these days of high-profile practice research, surely there is a project here begging to be taken up (since the Royal Pharmaceutical Society has yet to do so). The Department of Health has, for some years, used the criteria of recruitment, retention and motivation as parameters in determining its pay offer to contractors. There are obvious problems in all three areas. Is it too much to hope that these will be addressed, even in part, in the offer which it is believed the DoH has made to the PSNC this week?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# CHEMIST & DRUGGIST

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## REGULARS

# Dobson targets inner cities with Health Action Zones

Health secretary Frank Dobson has proposed the setting up of Health Action Zones to improve health in inner-city areas by integrating arrangements for treatment and care.

Primary healthcare professionals, as well as local authorities, the voluntary sector and local businesses, will be invited to draw up a health strategy for each area, which they would then implement. Funding for the "small number" of zones (thought to be about eight) would be expected to come out of "existing resources".

Mr Dobson made the announcement last Wednesday at the first NHS Confederation annual conference, held in Brighton. A discussion paper has been formulated and Mr Dobson hopes to publish a White Paper containing details of the HAZs in the autumn. However, he thought it unlikely that the initiative would be ready to go ahead with other planned pilot projects on April 1, 1998.

"I envisage that within the HAZs, health authorities, trusts, GPs, nurses, health visitors, pharmacists, dentists, opticians and all those involved in delivering the NHS on the ground will be brought together to develop a strategy for that area in partnership with local authorities, user groups, the voluntary sector and local businesses," he said.

President of the Royal Pharmaceutical Society Peter Curphey welcomed the move in principle. "We await with interest the White Paper that will detail how these new, co-ordinated arrangements will be developed," he said. "Pharmacists working across the community, hospital and shared care sectors are already working to build the kind of health-creating alliances outlined in the secretary of state's speech."

The Pharmaceutical Services Negotiating Committee's general secretary, Stephen Axon, also awaits the consultation document, saying that PSNC will be looking very carefully at the range of contents.

Mr Dobson blamed the internal market for eroding fundamental beliefs in the NHS. He said that the internal market "is clinically unsound because need and need alone no longer decides who gets treated or when they get treated". Instead, he reinforced the notion that the NHS should be available to all.

Committing himself to improving efficiency within the NHS, he said: "I and my ministerial colleagues will wage relentless war on waste whenever and wherever we find it." Particular areas to be tackled include savings on management and invoicing procedures, as well as "rooting out prescription fraud".

# £2m for Primary Care Act pilots

The Government is giving health authorities £2 million to develop personal medical services pilots with GPs and other members of the primary care team.

Health minister Alan Milburn told a press conference on Tuesday that the Government was going ahead this year with two types of Primary Care Act pilots – a move towards salaried GPs to improve recruitment and retention, and plans to get GPs, community nurses and other professionals working as a single team in the community.

"The patient will get the benefit of a primary healthcare one-stop shop," he explained. But pilots of unified budgets, in which primary and secondary care funding for an area would be combined, have been deferred until April, 1999. The Government had first to explore its proposals for Health Action Zones (see left), which would bring together local social and healthcare budgets, he said.

Mr Milburn ruled out the possibility of commercial organisations, such as supermarkets, providing general medical services, but he would be happy for trusts to do so, so long as firm protocols ensured there was no conflict of interests likely to damage patient care. Patients who saw a GP in hospital would have the advantages of access to a permanent GP rather than a locum, and there would be a better integration of primary and secondary care.

When asked whether pharmacists would come into the category of 'other professionals' encouraged into the 'one-stop shop', he referred the question to Mike Farrar of the Department of Health's primary care sector. Mr Farrar replied that the initial intention was to encourage greater integration of pharmacists in a complementary way rather than a wholesale move into health centres.

Pharmaceutical Services Negotiating Committee general secretary Stephen Axon noted with interest that pilots announced by Mr Milburn would commence in April, 1998, and would include dental pilots. However, he will be watching the development of the 'one-stop shop' centres for the consequences they will have on pharmacy contractors.

One example of a personal medical services pilot involving GPs and pharmacists which could be taken forward is the one-stop shop in Newark, where Dr Alan Hutton is to include optometry, osteopathy, dentistry and lay counselling, as well as pharmacy among the services on offer.

# HAs must recognise pharmacy social care contacts

There is a high level of contact between the public and community pharmacists on non-medicine-related issues that health authorities should recognise, according to Jeffrey Worrall, South Derbyshire Health Authority's director for primary care.

After a survey of Worksop pharmacies had shown 58 of 769 'contacts' between the public and pharmacists had an element of social care, Mr Worrall said it was remiss of the health service not to connect through a network which already existed.

He was speaking in a debate organised by the National Pharmaceutical Association at the NHS Confederation conference in Brighton last week.

He believes HAs can do more to improve and support pharmacy professionalism. "HAs need to give some focus and work closely with social services departments, which see the importance of pharmacy care and social care working together to keep people healthy," he said.

To do this he suggested there needs to be some clarity from the secretary of state, as to have a national policy.

Areas where pharmacists could be utilised more, he said, include training other health and social care workers in the proper use of medicines; delivering direct services; supplying aids to daily living; encouraging compliance; and supervising addict programmes.

Speaking with Mr Worrall was Martin Sheaves, chairman of the Association of Directors of Social Services. He highlighted conclusions from a draft report on medication management, which has been prepared by the NPA for publication at the ADSS conference in October, agreeing with the following.

- parties involved in caring for people must recognise that dedicated management is an important factor in improving and maintaining health
- whatever the reasons for adherence to medication, those purchasing and providing services must share responsibility for assisting any persons to overcome the difficulties found
- the prescribing and supply of medications may be the responsibility of those within the health service, but both social and health issues hinge on the ability to manage medication.


**The Pharmaceutical Services stand at the NHS Confederation exhibition was a joint venture by the RPSGB, PSNC and the CPPE. Besides promoting the profession's services, publications on a range of issues were distributed. Pictured on the stand were (from left) PSNC assistant secretary Mike King, Vanessa Taylor from Boots, RPSGB head of practice Roger Odd and Mark Dasgupta of Boots**

# CE increasing, says Scots PQE report

There has been a 20 per cent increase in pharmacist contact hours for local and national direct education and training, and distance learning, according to a report published this week.

This has been achieved with no financial increase in resources for 1996-97, compared with the previous year, and represents value for money in education and training, says the annual report of the Post-Qualification Education Board for NHS pharmacists in Scotland. The total number of contact hours was 21,900.

For distance learning courses there was an 85 per cent increase in contact hours compared with 1995-96, and the uptake of packages rose by about 120 per cent.

The PQE Board funded 52 pharmacists on postgraduate degrees or diplomas, of whom 47 were hospital and five community.


**The homeless in Edinburgh are being treated to free sunblock donated by Boots the Chemists. Following a high incidence of sunburn and blistering among the homeless last year, Edinburgh Streetwork Project wrote to the company, asking if it could spare any samples of sunblock to give out to the 300 sellers of the *Big Issue* in the city. Boots was happy to supply, commenting that damage by the sun affects everyone, with potential long-term effects**

# Announcement on paracetamol due

A statement on control of paracetamol expected from the Medicines Control Agency is thought to be imminent.

As *C&D* went to press on Wednesday, a Department of Health spokesman commented: "There is something in the wind. I don't expect it to be much longer, but I don't know when it will be."

# NPA and HEA agree smoking guidelines

The National Pharmaceutical Association has joined forces with other professional organisations in a Health Education Authority initiative to agree national guidelines for smoking cessation counselling. The aim is to improve the quality of advice and support given to smokers.

Georgina Craig, NPA head of professional development, says: "The NPA has been working with the HEA to develop these guidelines, which follow closely the smoking cessation protocols in the PAS model. This important HEA initiative will provide additional support to help pharmacists increase awareness of the need to stop smoking."

The guidelines will be developed from evidence-based best practice and launched to health professionals after consultation with the various groups. The project also aims to persuade commissioners to include smoking cessation advice in their contracts with trusts.

HEA research found that only 28 per cent of smokers had discussed smoking with a health professional in the past year, and that only 35 per cent of those who did so found that advice to be useful.

# 'GP dispensing' goes on trial

Pharmacists and doctors 'went to war' in the High Court last Thursday over whether GPs can delegate dispensing to unqualified and unsupervised staff.

Pharmacists in Caistor, Lincolnshire; Beverley, Humberside; and Westerham, Kent, are challenging decisions by their health authorities to grant dispensing applications from doctors.

In a major test case, Justice Owen was asked to agree to a judicial review of the go-ahead given to the dispensing doctors on the grounds that GPs should not be allowed to delegate the supply of medicines, but should have to supply them personally.

Judgment in the case has been reserved.

If the application succeeds, the practice of 'delegated doctor dispensing' is almost certain to be outlawed. The application is officially by Selles Dispensing Chemist of Chessington, and Elmfield Drugs of North Woolwich against the Family Health Services Appeal Authority.

The Authority, however, is not attending the hearing and has made it clear in a submission to court that it considers that this is an issue between pharmacists and doctors.

Duncan Ouseley QC, for the pharmacists, said the central issue in the three applications focused on whether a doctor could delegate the supply of medicine to patients under the 1968 Medicines Act.

The essence of the applicants' submissions were that, where a doctor supplied medicines to patients, that activity "cannot be delegated to an employee or performed by an employee acting under the supervision of a doctor.

"The applicants contend that this practice is unlawful and that delegated doctor dispensing is inconsistent with the scheme for the distribution of medicines established by the contemporary legislation," commented Mr Ouseley.

Michael Beloff QC, for the GPs, said the law did not require that medicines must be dispensed, or at least supervised, by a qualified person. Since the doctor's staff were only acting in accordance with a prescription, they were acting "entirely legally", he said.

The GPs, in company with the Appeal Authority, asserted that they were permitted to use their staff to dispense medicines.

Mr Beloff submitted that under the Medicines Act 'agents' were allowed to give out medicines to patients under the control of a GP. The Medicines Act "does not add the requirement that the sale or supply by an unqualified agent must be supervised by a qualified person", said Mr Beloff.

Mr Justice Owen reserved judgment until a date to be fixed.

# 'Tremendous response' for sleep aid audit

Issuing of results of the first national pharmacy sleep aid audit have been delayed because of the overwhelming response from pharmacists.

The audit into purchases of antihistamine-based sleep aids has had responses from 2,400 pharmacies or 20 per cent of all outlets in Britain, with replies still coming in. The audit was carried out in May (*C&D* May 3, p4).

Royal Pharmaceutical Society research fellow David Pruce explains that more time has been taken than expected to input replies into the computer due to the "tremendous response".

However, he hopes to get the first information of individual results returned to pharmacies by the end of this month. This will precede a formal paper on the audit.

## Salbutamol alert

**Generics (UK) is recalling further batches of Salbutamol Aerosol Inhalation 100mcg/dose as a precaution, after a small number of inhalers were found to have defective metering valves (*C&D* June 28, p5). The batches are: Generics (UK) 9675S1, 9676S1, 9677S1, 9678S1, 9707S1, 9708S2, 9720S1, 9721S1, 9721S2, 9722S1, 9723S1, 9724S1, 9725S1, 9726S1, 9727S1, 9728S2; Hillcross 9708S1. All contain 200 doses and have an expiry date of December, 1999 (Class 2 alert, issued June 30). Information from Generics (UK). Tel: 01707 853000.**

## PPA payments

**The Prescription Pricing Authority has issued a special edition of PPA Matters detailing the new monthly payment schedule (FP34) and expensive item report, which will be sent to contractors in England and Wales. The first of these, relating to the July 1 payment, should have been received by June 27.**

## Pharmacy's ambassador

**The National Pharmaceutical Association's head of professional development, Georgina Craig, addressed the Association of Multifunds this week on the benefits of pharmacists and GPs working together.**

## CHC constitution

**The Consumer Health Council proposed by the Proprietary Association of Great Britain (*C&D* June 28, p30) will consist principally of individual health professionals, not the professional institutions listed.**

## Cannabis day

**The postponed 'Therapeutic Applications of Cannabinoids' symposium will take place on July 8 at the Royal Pharmaceutical Society. Details from the RPSGB on 0171 735 9141.**

## IPMI AGM date

**The Institute of Pharmacy Management International annual general meeting will now be held at the Forte Coventry Hill Hotel, Rye Hill, Allesley, Coventry, on July 13 at 2.00pm.**

## Selected List

**Regulations have been published implementing changes to the Selected List in Scotland from July 1. The NHS (General Medical Services) (Scotland) Amendment (No 2) Regulations 1997 (No 1473; S117) bring about similar changes to the rest of the UK.**

# Super-surgery gets go-ahead

Cheltenham Borough Council's decision to go ahead with a new super-surgery will result in a massive closure of pharmacies, local contractors claim.

The family healthcare centre, serving 46,000 patients and including a pharmacy, would be built on the former St Paul's Maternity Hospital site. Six independent pharmacists set up a consortium and applied for permission to dispense from the centre in the belief that this was the only way to prevent pharmacy closures elsewhere in the town when five GP practices move to the new site.

Peter Badham, one of the contractors in the United Chemists Association consortium, told *C&D* that they will write to the Department of the Environment and the Ombudsman to complain about the way in which planning permission was granted.

He said a report submitted to the planning committee by the developers contained inaccurate data, claiming that a new surgery would cause minimal damage to pharmacies. Mr Badham believed the true situation was that half the outlets in Cheltenham would close within three years.

The council went ahead with planning permission despite some councillors wanting the decision delayed while the figures were checked. Another survey, by the Labour Party, found that only 5 per cent of patients favoured the new development.

Gloucester Health Authority is holding an oral hearing on July 11 at which it will consider two applications to dispense from the site – one from the consortium and another from Mohammed Ihsan, an independent contractor from Solihull. Mr Badham said the consortium put in an application last November and believed the health authority had caused unnecessary delay by mistakenly arguing that the consortium needed a superintendent before it opened. The authority was unable to comment further on the case.

# Scottish Executive's MP briefings

The Royal Pharmaceutical Society's Scottish Department Executive is looking at ways of briefing Scotland's new MPs on pharmacy. Members will also be encouraged to contact their local MPs.

The Executive agreed at last month's meeting to hold a dinner for key people at a date when it might be possible for the Scottish health minister to attend.

Christine Glover, the Society's vice president, reported that guidelines were being put together in Lambeth for the five devolved services in Scotland. The guidelines would be circulated to Executive members for consultation. Those for residential homes and methadone dispensing have been completed.

Following the launch of the Association of Scottish Trust Chief Pharmacists' training programme in Edinburgh on May 8, the Executive decided that the Continuing Professional Development Group should look at how a similar formal training course could be translated to the community pharmacy sector.

The registration ceremony for new members will be held at York Place on September 10.

# Sandwell HA's two new pilot schemes

Sandwell Health Authority is launching two pilot schemes in which community pharmacists make domiciliary visits and help GPs with prescribing.

Starting this autumn, up to three pharmacies will review the medication of housebound patients identified by the primary healthcare team, in a pilot costing £15,000. Another scheme, with about £30,000 funding, will look at the part pharmacists can play in repeat prescribing reviews and formulary development.

Pharmaceutical adviser Peter Matthews told *C&D* that the health authority's June meeting accepted a strategy for developing community pharmacy in which a liaison group will discuss with the local pharmaceutical committee the adequacy of local pharmaceutical services.

# Prescription drugs can cause road deaths

Over a quarter of car drivers killed in road accidents are found to have traces of medicinal or illicit drugs in their bodies.

This is one of the first findings of a three-year Department of Transport survey, started last October. Results taken from 301 road deaths in the first seven months indicate illicit drug-taking has increased fourfold since a similar study was done between 1985-87.

Tests are made for drugs affecting the central nervous system in drivers, riders of two-wheel vehicles, passengers and pedestrians killed in road accidents. Among the medicinal drugs being tested for are tranquillisers, hypnotics and anti-depressants.

Positive tests for medicinal drugs were found in 6 per cent of deaths. This represents an average of 18 deaths per month, although the figures do not show how many deaths were caused by the drugs.

# Morecambe targets paracetamol dangers

A campaign to highlight the potential for problems in paracetamol overdose has been launched in the Morecambe and Lancaster areas.

Over 200 posters have been distributed to pharmacies, GP surgeries, supermarkets and other retailers, saying 'Too much paracetamol can kill – do not use paracetamol as a cry for help'. It stresses that the recommended dose should not be exceeded.

The scheme has been set up by the local Accident Prevention Partnership with Morecambe Bay Health Authority, after the Royal Lancaster Hospital accident and emergency department expressed concern over the number of people treated for paracetamol poisonings. Last year, out of 555 admissions for poisonings, 176 involved paracetamol.

Pharmaceutical adviser Andrea Lowdon says the scheme is based on a campaign organised by the Alder Hey Hospital.

# Teamwork in Dorset

Community pharmacists and general practitioners in Dorset are working together to encourage patients at risk from heart disease to take low-dose aspirin.

Dorset LPC and LMC, supported by Dorset Health Authority, have produced a poster to make patients who have suffered a heart attack, stroke or angina aware of the benefits of low-dose aspirin.

The poster will be displayed in 105 surgeries and 139 pharmacies throughout Dorset for three weeks from June 23.

"We are pleased to be working with pharmacists in supporting this important health promotion message which is based on the latest medical evidence and best clinical practice," said Dr Chris Playfair, a GP from Poole.

N IRELAND NOTEBOOK

# Ignorance is bliss

On a recent visit to the Republic of Ireland, I was impressed at the widespread pharmacy window advertising for Persona, the contraceptive device that caused so much controversy in the UK.

Where I still harbour concerns at the way Unipath introduced Persona here, I share the company's dismay at the way the product was treated in a 'Watchdog' programme on BBC1 a month or so ago.

Studies prove Persona, when used by well informed women, has similar efficacy to the condom. The general public seem not to realise the condom is only 94 per cent effective.

Blissfully unaware of the statistics of reality, the public don't appear to appreciate that black and white does not exist and, as a result, they are easily confused by the media, skilful in putting a newsworthy slant on the facts.

'Watchdog' used anecdotal testimonies from women who had become pregnant while using Persona. Many more contacted the programme during transmission to claim that they, too, had become pregnant. This public jury 'proved', in a very unscientific manner, that Persona was more unreliable than claimed. Wrong!

> The public seem not to realise the condom is only 94 per cent effective

People now seek more information on their health than they did 20 years ago. They use this information to make decisions and, while this must be viewed as a positive development, it falls down when they are unable to understand the facts presented.

There is a catalogue of such issues in addition to Persona: BSE, water fluoridation in N Ireland and, more recently, the adverse publicity on terfenadine. None were treated rationally on the science available because the public were unable to understand the facts.

Such ignorance does not serve well and if we aspire to be public advocates on health, we need to become skilled in understanding risks and advising on the meaning of these risks. Failure to do this will affect our business, as it might destroy many good products that make us profit.

*Written by a practising Northern Ireland community pharmacist.*

# Topical Reflections

## NHSE review needs close attention

An important consultation exercise on prescribing and dispensing is presently being undertaken by the NHS Executive, but time is short if pharmacists' views are to be considered (*C&D* June 28, p6). To its credit, the NHSE is not only seeking the views of representative organisations but also those of individual practitioners, and I intend taking up the offer.

I know pharmacy practice is perennially at a crossroads, but a new administration has coincided with information technology capability that could truly revolutionise the way we practise. The debate about electronic prescriptions is serious and well documented, but this consultation exercise from the NHSE on prescribing is a fundamental review that we ignore at our peril.

In the Royal Pharmaceutical Society's 'Pharmacy in a New Age' initiative, we were asked to predict the future without preconceived restrictions. The result has been a dynamic blueprint for the future. This NHSE initiative has the potential to do the same thing for the prescribing and supply of medicines.

The question revolves around prescribing responsibilities and whether, if the slate were clean, the present system or one radically different would be the natural choice. The answer has to be based on a knowledge of how all the health professions presently operate and interact, but most importantly on what system would produce the best service for the patient at the most effective cost to the taxpayer.

The opinions of contributors will vary widely, but this is a review from which the NHSE has deliberately removed the blinkers so often kept in place by professional protectionism. I believe that prescribing and prescription management by pharmacists should be a preferred option because, uniquely, community pharmacists are ideally placed to provide a convenient, cost-effective and safe service to both the NHS and private sectors.

The future of community pharmacy could lie in this possible redefining of the lines of demarcation, so it is essential that our voice is heard, loud and clear.

## No fudge please, but a final solution

The problems of dispensing in rural areas refuse to go away, and will not do so until some sense can be agreed on a rational approach to the legal controls.

The so-called loophole which allows pharmacists under contract in the same health authority area to open without reference to the Clothier regulations is castigated by the medical lobby when, at the same time, the abuse by their own members of the regulations in market towns is ignored.

Presently, the two professions are arguing over the delineation of rural areas around Chichester, while at the Local Medical Committees Conference a two-edged motion was passed which instructed the General Medical Services Committee to work to secure closure of the loophole without conceding on other issues.

I view this motion as another example of the doctors' desire to have their cake and eat it, but Dr David Baker, chairman of the GMSC's rural practice subcommittee, sees it as an opportunity for constructive negotiations.

He would like a redefinition of the word 'prejudice' in the Clothier regulations which could serve to help both dispensing doctors and pharmacists. This is a position that only an experienced politician could adopt ... confidently facing both ways at the same time!

However, to be fair to Dr Baker there is some sense in his position, because the root problem that should be addressed is the solution that is best for rural communities. It has been shown that community resistance to a pharmacy opening soon evaporates once the services of that pharmacy are experienced.

A fundamental review of the provision of health services in rural areas needs to be undertaken and I would prefer the long, hard road needed to produce a final solution than the temporary fudge that a 'loophole' trade-off would produce.

If the two professions can, in harmony, provide a first class service to rural communities in Scotland, then it should not be too much to expect that in England and Wales, with their much larger populations, similar working relationships can be agreed.

## Bayer pack changes

**Ciproxen tablets 100mg now come in a new six-tablet pack (basic NHS price £2.80) in addition to existing sizes. Bayer has also discontinued DTIC-Dome (dacarbazine) 100mg. The 200mg strength of the cytotoxic is still available, but in limited supplies because of a worldwide shortage.**
**Bayer plc. Tel: 01635 563000.**

## Generic oxybutynin

**Generics UK has launched oxybutynin tablets in 2.5mg and 5mg strengths (84-tablet packs £10.80 and £21.05 respectively).**
**Generics (UK). Tel: 01707 853000.**

## Cox ranitidine

**Ranitidine tablets 150mg (60, £23.70) and 300mg (30, £23.30) have been introduced by Cox.**
**Cox Pharmaceuticals Ltd. Tel: 01271 311200.**

## Genus steps in

**Genus has introduced ethambutol tablets in 100mg (100, £9.03) and 400mg (100, £32.30) strengths and benzhexol tablets 2mg (100, £2.33) and 5mg (100, £4.53) strengths. These replace Artane and Myambutol, which have been discontinued by Wyeth.**
**Genus Pharmaceuticals. Tel: 01628 604377.**

## Nestargel is back

**Nestargel is back in stock after a recent shortage brought on by extra demand. All outstanding orders have been dispatched.**
**Nestle UK Ltd. Tel: 0181 686 3333.**

## RPR to Manx Pharma

**RPR has divested the following products to Manx Pharma: AAA Mouth and Throat Spray, Avomine tablets 25mg (ten- and 20-tablet packs) and Brulidine 25g tube. Marketing and distribution will now be handled by Manx.**
**Manx Pharma. Tel: 01622 766389.**

## Cozaar-Comp from MSD

**Cozaar-Comp (50mg losartan 12.5mg hydrochlorthiazide) has been introduced by MSD for the treatment of hypertension in patients whose blood pressure has been stabilised on losartan and hydrochlorthiazide given separately in the same proportions (28-day pack, £17.23 basic NHS).**
**Merck Sharp & Dohme. Tel: 01992 467272.**

# Palladone – an opioid alternative to morphine

Palladone is being launched by Napp as an alternative opioid to morphine in the treatment of severe cancer pain.

The Palladone range, which includes standard and controlled release formulations, contains hydromorphone HCl, a mu-receptor agonist and a semi-synthetic congener of morphine. Until now hydromorphone has been available on a named patient-only basis.

Hydromorphone is expected to benefit patients who cannot tolerate morphine or whose pain is poorly controlled with it. Hydromorphone is similar to morphine in terms of pain control, tolerability and dosing patterns.

Hydromorphone may also be used in opioid rotation regimens to reduce opioid toxicity associated with long-term therapy.

Palladone is available in standard formulation 1.3mg (56, basic NHS price $8.67) and 2.6mg (56, $17.34) capsules for initial titration. It should be used at four-hourly intervals.

Palladone-SR capsules are also available for maintenance therapy and are given at 12-hourly intervals. They come in 56-capsule packs in the following strengths: 2mg ($18.42), 4mg ($25.24), 8mg ($49.22), 16mg ($93.52) and 24mg ($140.32).

Palladone and Palladone-SR carry a legal category of CD (Sch2) POM. The range is available from July 9.

**Napp Laboratories Ltd. Tel: 01223 424444.**

MEDICAL MATTERS

# Suicide with medical disorders overlooked

The link between suicide and medical disorders is often overlooked. More attention is paid to the more established association with psychiatric disorders.

A meta-analysis has been undertaken by the University of Southampton comparing mortality rates in medical disorders said to have an altered suicide risk. The number of observed suicides was compared with expected numbers, and a standardised mortality ratio calculated for each disease.

Increased suicide risk was seen for HIV/AIDS, malignant neoplasms, head and neck cancers, Huntingdon's disease, multiple sclerosis, peptic ulcer disease, renal dialysis, spinal cord injury and systemic lupus erythematosus. Pregnancy and the postnatal period had a decreased risk compared to normal.

- The Royal College of Psychiatrists has produced a 'Help is at Hand' leaflet on manic depression. That and other leaflets are available free by sending an SAE to the RCP, 17 Belgrave Square, London SW1X 8PG.

# Inequality of care faces schizophrenics

Patients with schizophrenia are faced with marked inequality in treatment and professional care.

The prescribing of the newer atypical antipsychotics, which have a wider application and fewer extrapyramidal effects, is being restricted by drug budgets and prescriber ignorance, says Bharat Mehta of the National Schizophrenia Fellowship.

Although the choice of drugs influenced compliance, failings in the social network also hindered compliance in patients in the community. Pharmacists have become essential in monitoring compliance and relapse, and advising patients, he says.

The National Schizophrenia Fellowship is currently looking to run a training programme for community pharmacists.

He was speaking at the launch of 'Target Schizophrenia', a new booklet from the Association of the British Pharmaceutical Industry. Copies are free from the ABPI, 12 Whitehall, London SW1A 2DY.

# Dovonex licensed for children

Dovonex (calcipotriol) ointment and cream have been licensed for the treatment of mild to moderate plaque psoriasis in children.

The new recommended dosage is a maximum 50g per week for children 6-12 years old, with a maximum 75g per week for children over 12 years old. The maximum dose has not been established in children under the age of six. The maximum for adults is 100g per week.

The new licence is supported by two studies which show Dovonex produced a marked improvement in 65 per cent of children treated, with clearance of plaques in 60 per cent of the group. Treatment was also considered cosmetically acceptable in 79 per cent of patients and was not accompanied by serious adverse effects.

Until now, the management of childhood psoriasis has been restricted to time-consuming and often cosmetically-unacceptable dithranol and tar-based preparations. Topical corticosteroids have also been used.

**Leo Laboratories. Tel: 01844 347333.**

# Nutricia rolls in the bread

Nutricia has added two new wheat-free rolls and a gluten-free part-baked loaf to its range of dietary products. All the new lines are available on NHS prescription.

Glutafin Multigrain White Rolls (six x 300g case, $15.55 trade) replace the existing Glutafin Wheat-Free White Rolls. The improved recipe means moist and light bread when refreshed in a conventional or microwave oven. New Glutafin Multigrain Fibre Rolls (six x 400g case, $15.54 trade) are based on the existing Fibre Loaf recipe. Both come in packs of four.

Glutafin Part-Baked Loaf (six x 400g case, $15.54 trade) is a new gluten-free white loaf which takes 20 minutes to oven bake. Once done, the loaf is claimed to have the taste and texture of traditional freshly-baked bread.

The rolls and the part-baked loaf have a shelf-life of four months and do not require freezing.

**Nutricia Dietary Products Ltd. Tel: 01225 771801.**

# FLYING DOCTOR



NEW

**Anthisan™ PLUS**

**STING RELIEF SPRAY**

mepyramine/benzocaine

**FAST, ANAESTHETIC STING RELIEF**

**ential Information. Anthisan Plus Sting Relief Spray. Presentation:** metered dose spray containing mepyramine maleate 2%w/w and benzocaine 2%w/w. **Indications:** Symptomatic ef in insect bites and stings, jellyfish and nettle stings. **Dosage:** Adults, elderly and children aver 3 years. Pressing the nozzle once delivers a single metered dose. Two to three metered doses to sprayed onto the site of the bite or sting, twa or three times a day far up ta three days. Early applicatian is essentiol to obtain optimum respanse. **Contraindications:** Hypersensitivity to any ne ingredients, eczemous conditions. Nat to be used an extensively braken skin or near eyes or mauth. **Warnings**: Repeated applications for langer than a few days are nat recommended treatment should be discontinued immediately if skin sensitisatian occurs. Spray should not be applied near naked flames. Effects an ability to drive and use machines: none when used as ommended. **Pregnancy and lactation:** should not be used unless considered essentiol by a physician. **Side effects:** hypersensitivity reactions. **Product licence no. PL**12/0309 held by Rhône-Poulenc Rorer, Kings Hill, West Malling, Kent, ME19 4AH. **Legal category** P. **RSP** 60 dose £3.49 180 dose £4.49. Prepared April 1997.TM - ANTHISAN is a Trademark.

r RHÔNE-POULENC RORER

# COUNTERpoints

## Colour scheme for Oil of Ulay

Procter & Gamble is extending its Oil of Ulay skin care brand into the cosmetics category on a national basis.

A September launch is planned for the Oil of Ulay Colour Collection which has been test marketed in south west England since summer 1996.

The company will be spending $2 million on a TV campaign to launch its cosmetics range in the autumn.

It also plans to distribute millions of product samples in a major sampling campaign.

According to Procter & Gamble, the range has achieved the best-ever test market results of any of its health and beauty care products in the UK.

The company aims to distribute the products in around 4,000 pharmacies, drugstores and groceries.

**Procter & Gamble Ltd.**
**Tel: 01932 896000.**

## Neutrogena steps out with first-ever foot care range

Johnson & Johnson has launched the first-ever Neutrogena foot care range with two therapeutic foot care products.

Neutrogena Foot Cream ($4.99, 50ml) and Refreshing Foot Spray ($5.99, 125ml) are designed to provide straightforward foot care solutions.


The cream is formulated to care for all types of dry, hard foot skin ailments. It has a non-greasy formulation which is rich in glycerine and humectant, and enriched with soothing anti-inflammatory agents.

Designed as a 'pick me up' for hot, tired feet, the spray contains soothing menthol ingredients to cool the feet without drying them out. It also includes antiseptic ingredients to aid in the prevention of micro bacteria and foot odours.

The launch will be supported by a poster advertising campaign on London Underground escalator panels during August and September.

A 'try me free' consumer guarantee is being offered at point of sale via coupons and leaflets. In-store display materials are available.

**Johnson & Johnson Ltd.**
**Tel: 01628 822222.**

## Deodorant spray benefits crystal clear

**Pitrok natural crystal deodorant has been introduced in a spray format.**

**The product has a natural anti-bacterial action and does not block the pores, allowing for elimination of toxins from the body.**

**Suitable for sensitive skins, the product does not contain any perfume. The skin conditioning formulation includes aloe vera, calendula and vitamin E.**

**Retail price is £3.95.**

**Pitrok Ltd.**
**Tel: 0181 563 1120.**

## Get fresh this summer with Gillette

Gillette is running a summer freshness promotion, especially for the independent pharmacist.


A free Natrel Plus Icini antiperspirant deodorant (rrp $1.95) is offered free with any purchase from the Sensorexcel for Women or Satin Care Shave Gel range.

A specially-designed display unit is available for independents, together with posters and window cards promoting the Natrel Plus offer.

**Gillette UK Ltd.**
**Tel: 0181 560 1234.**

## Kamakura: full of Eastern promise

Kamakura is a new range of bath and hair care products based on Oriental medicinal herbs.

Named after the ancient capital of Japan, the range is designed to be concentrated yet mild. Herbs have been added at between 3 and 6 per cent in all formulations.

The bath care products contain a water-soluble form of jojoba oil to give a smooth skin after bathing. The shampoos and conditioners all have panthenol, wheat protein and silk amino acids. The conditioning creams have ceramide added and all contain silk.

Retail price is $4.99 each for 250ml, except the conditioners which retail at $5.99.

**Alchemy International Ltd.**
**Tel: 0181 401 2510.**

## Taking the 'woolly' out of cotton wool

Smith & Nephew is relaunching its Tender Touch range of cosmetic cotton wool.

The cotton wool balls are now manufactured under a new process which increases the product's absorbency, making it softer and fluffier than before.

New packaging is designed to give the brand a more modern, distinctive image. It also makes the range easier to differentiate from Tender Touch Baby.

Pack formats have been condensed – cash and carry packs are reduced to fours and retail packs to 12s and 16s. Retail prices range from $0.69 for 60g cotton wool pleats to $1.79 for 80 covered cotton wool pads.

**Smith & Nephew Consumer Products Ltd.**
**Tel: 0121 327 4750.**

## Cussons gives that 'healthy feeling'

**Cussons is spending £1.9 million on advertising its Carex Personal Wash range during July/August.**

**The campaign includes TV, press, radio and London Underground advertising.**

**It features specific products – Bodywash, and Bath Foamwash and Bar – while stressing the 'healthy feeling skin' benefits offered by the entire range.**

**The advertisements in women's magazines feature 1.7 million Bodywash and Bath Foamwash samples. An additional 4.5m money-off vouchers will appear in August issues.**

**Cussons (UK) Ltd.**
**Tel: 0161 491 8000.**

## Natural look for Radox Wheatgerm

Sara Lee has introduced a fresh look for its Radox Wheatgerm range of bath and shower products.

Targeting young families, the bright new packs are designed for clearer communication of the brand's 'moisturisers from nature' message.

The packaging emphasises the brand's wheatgerm proposition to reinforce its position in the natural sector.

Retailing from $1.69 to $2.99, the range includes shower gel, bath and shower gel, foam bath and liquid soap.

- The growing natural sector now accounts for $2.9 million of the bath and shower market (IRI Infoscan MAT, April, 1997).

**Sara Lee UK Ltd.**
**Tel: 01753 523971.**

# Seal & Heal

## VERRUCA REMOVAL GEL

### *a new effective, easy to use, plaster-free verruca treatment*

Scholl, the market leader, with a **57%** share of the **£30.1 million*** Footcare Market, is launching an effective, easy to apply verruca treatment which requires no plaster. Making it ideal for children who are in the majority when it comes to suffering from verrucas.

**Scholl's new Seal & Heal Verruca Removal Gel** will be launched and introduced to health professionals, at the annual Scholl Nurses Exhibition and Conference, in July.

**New Seal & Heal** is an effective, water resistant barrier product which requires no plasters and is easy to apply. You simply apply one or two drops of **Seal & Heal Gel** directly on to the verruca and allow to dry. Treatment is repeated daily until the verruca can be removed. **Seal & Heal** is great for kids who love to go swimming - no one needs to know they have a verruca!

**RRP £3.95**
**5ml tube Packed in 6's**



## *Marketing Support*

Scholl is supporting the launch with a full marketing package including a consumer press and poster advertising campaign which is part of a **£1.5 million** investment in advertising by Scholl this year.

## *Point of Sale*
### *Package for pharmacists*

1. Giant 3-D Seal & Heal packs for window displays
2. Counter display units
3. Shelf wobblers
4. New educational unit featuring the product for the Scholl racks all aimed at drawing customers attention to the new product.

## *Tips for infection-free feet*

***To help prevent verrucas and other foot infections Scholl offers the following advice:***

- ***Try to avoid walking barefoot in areas such as public swimming pools and communal changing rooms.***
- ***Bath your feet daily, thoroughly drying between the toes. It is essential to ensure that feet are clean and dry with good air circulation.***
- ***Change shoes and socks (or hosiery) daily.***

## *Did you know?*

***Around 10% (5.7 million) of the UK's population has suffered from verrucas and 82% (4.7 million) of sufferers are children under 15 years of age, but still only 42% treat.***

***Seal & Heal provides a no mess, no nonsense, effective solution to verruca treatment, which is ideally suited to children who are active and do not want to be marked out as having a verruca.***

*Nielsen: Sterling Sales MAT April 1997

**ODUCT INFORMATION**

entation: A topical solution containing 11.25% W/V Salicylic Acid BP and 2.8% W/V Camphor BP. **Indications:** For the self treatment of common and plantar warts, corns and callouses.

inistration:
& Heal Verruca Removal Gel should be topically applied twice daily for corns and callouses and once daily for warts and verrucas. No distinction is made between different categories of patient.

dren under 12 years: Should seek medical advice before use. **Contraindications:** Not to be used by diabetics or patients with severe circulatory disorders, except following a doctor's permission and mmendation. Not to be used if the corn, callous, wart, verruca or surrounding skin is inflamed or broken. Not to be used in patients who are hypersensitive to Salicylic Acid or any other ingredient e preparation.

er Special Warnings and Precautions: Discontinue use if excessive discomfort or irritation is experienced, or if sensitivity develops. Do not apply to normal skin. If liquid comes into contact with normal wash off immediately with water.

**Interactions:** None stated **Other undesirable effects:** Local irritation or dermatitis may occur **Overdosage:** Not applicable **Legal Category:** GSL

# Steradent goes Extra fruity

Reckitt & Colman is relaunching Steradent Extra Strength with a new fruit acid formulation.

On-shelf in July, the product has been reformulated to provide improved tartar and stain removal. It will retail at £1.39.

The company's research shows that consumers find the new product has a fresher taste than the previous one.

The Steradent brand is being supported by a £250,000 advertising campaign in consumer magazines until September.

Featuring the 'Steradent Challenge', the advertisements include laboratory test results to communicate the benefits of Steradent over ordinary toothpaste when cleaning bacteria and plaque from dentures.

**Reckitt & Colman Products.**
**Tel: 01482 326151.**


## Sweet talk

**From July 14, Chemist Brokers will be distributing Mars' Tunes and Lockets to independents.**
**Chemist Brokers.**
**Tel: 01705 222500.**

## Getting it taped

**Further to 'Women's Health' (*C&D* June 14), Albert Smith Health Cassettes (rsp £5.95) are available from:**
**Albert Smith.**
**Tel: 01255 672031.**

## Memory keeper

**From July 21 to August 13, Kodak Advanced Photo System wallets will contain a voucher for a free Memory Keeper.**
**Kodak Processing.**
**Tel: 01442 845387.**

# Join the sweetest club around

Hermes Sweeteners is launching The Hermesetas Plus Club for consumers.

Promoted on-pack, the club can be joined by sending in two Hermesetas logos from any product in the range. Members will receive lifestyle cards featuring recipes, offers, hobbies, competitions, etc.

All the cards can be kept in a special binder complete with divider cards for easy reference. A number of packs are planned each year with consumers being requested to provide two further proofs of purchase to receive each one.

**Hermes Sweeteners.**
**Tel: 0171 836 3927.**

# Robot adds power to Feldene P Gel

Pfizer is supporting Feldene P Gel with a £1.9 million TV campaign this month.

The commercial features a prototype robotic production arm which breaks down. A laser beam then helps to restore it. At the same time, the engineer feels pain in his hand joints and reaches for Feldene P Gel to gain relief from mild arthritis.

Tests for the ad show that people identify the dysfunction of the robotic arm with their own problems when suffering from the stiffness and pain of arthritis.

**Pfizer Consumer Healthcare.**
**Tel: 01420 84801.**


# Pharmacy deal from Monmouth

**Monmouth Pharmaceuticals is offering pharmacies a 50 per cent profit on return as standard on all its pharmacy OTC products, starting from this month.**

**This move is equivalent to a 100 per cent mark-up on the trade price and is irrespective of the volumes purchased.**

**The company's products include Mintec capsules for the treatment of irritable bowel syndrome, Expulin cough medicines and Enterosan anti-diarrhoeal tablets.**

**Monmouth Pharmaceuticals Ltd.**
**Tel: 01483 565299.**

# The natural solution for dry throats

Ceuta Healthcare has introduced Islamint Herbal Lozenges with Iceland Moss Extract in the UK.

The product is a natural solution to relieve a dry throat and blocked airways caused by environmental factors like air-conditioning.

It is designed to moisten and ease the air passages, and protect the mucous membranes of both the mouth and throat.

The formulation contains Iceland Moss, which is widely recognised as a herbal remedy for coughs and congestion.

Suitable for all the family, the product has a fresh, minty taste and a sugar-free formula. Retail price is £1.49 for 20 lozenges.

**Ceuta Healthcare Ltd.**
**Tel: 01202 780558.**


# On guard against the summer bugs

Bug Guards is a new insect repellent from Go Travel Products which aims to protect against mosquito and other insect bites.

It comes as a set of four fully-adjustable bands, which can be worn around the wrists or ankles.

Each band is impregnated with DEET using a micro-encapsulation technique. The bands remain dry, while the DEET releases a 'protective halo' with the natural movement of the body. No chemical absorption into the wearer's skin occurs.

Suitable for children and those with sensitive skin, the product retails at £6.99.

**Jack Rogers & Co Ltd.**
**Tel: 0181 906 8505.**

# ON TV NEXT WEEK

**Bazuka:** C, CAR

**Clairol Herbal Essences:** All areas

**Clarityn Allergy:** C, GMTV

**Colgate Sensation toothpaste:** All areas

**Dettol Antiseptic Pain Relief Spray:** All areas

**Feldene P Gel:** LWT, CAR, C4, C5, Sat

**First Response:** All areas

**Jungle Formula:** C, A, HTV, W, M, GMTV

**Listerine:** C, A, M, LWT, CAR, C4, Sat

**Pantene:** All areas except GMTV

**Pepcid AC:** TT

**Regaine:** C, C4, LWT

**Soft & Gentle:** All areas

**Wella Experience:** C4

**Wilkinson Sword FX Performer:** All areas

**A** Anglia, **B** Border, **C** Central, **C4** Channel 4, **C5** Channel 5, **CAR** Carlton, **CTV** Channel Islands, **G** Granada, **GMTV** Breakfast Television, **GTV** Grampian, **HTV** Wales & West, **LWT** London Weekend, **M** Meridian, **Sat** Satellite, **STV** Scotland (central), **TT** Tyne Tees, **U** Ulster, **W** Westcountry, **Y** Yorkshire

# Rest assured

Nytol is the undisputed brand leader in a market of its own making, with a rate of sale more than 5 times greater than its nearest competitor[1]. Nytol, which contains diphenhydramine, is the product of choice for millions of people all over the world. The Original Nytol comes in 25 mg tablets, for those customers who may not use the full dosage, there's also the convenient One-A-Night with its 50 mg single dose formulation, and now there's the all natural Herbal variant hot on its heels.


We know that 91% of consumers feel Nytol is a brand they can trust[2], and with Stafford-Miller's continued commitment to developing this brand, and with it the market, you can be sure, as ever, good profits *only* follow a good Nytol.

**If you think there's anything better than Nytol – dream on.**



STAFFORD-MILLER AND YOU – BUILDING BRAND LEADERS.

# Chemex 97 – bigger and better

With over two months to go to Chemex 97, exhibitors have already snapped up more than 90 per cent of the stand space, making the event even bigger than last year.

Andy Gibb (right), event director, says: "We are delighted with the response from the industry. Chemex is already established as the leading exhibition in this marketplace and it will be even bigger and better this September. Around 3,500 independent retail pharmacists and multiples are expected to attend the event."

He is confident that Chemex will be the largest gathering of manufacturers and pharmacists in any one place this year. "It is an essential industry forum which is a 'must' for manufacturers and visitors alike."

The event's organisers are spending over £100,000 on a targeted visitor promotional campaign – the largest in the exhibition's history.

Visitors will have the chance to attend retail seminars, win a dream holiday and receive a voucher book worth thousands of pounds. There is also a chance to take advantage of a discount 'showstopper' travel package.

A key feature of the show will be a model shop which will illustrate the most effective ways of presenting and placing products in pharmacies. It will focus on areas including merchandising, layout, lighting and shelving.

Procter & Gamble, Unichem and Moss Advisory Services will be among the companies participating in this innovative feature. Design and construction will be undertaken by pharmacy shopfitter Crescent Installations.

For free tickets call the ticket hotline on 01203 426482. Pre-registered visitors will be entered into the holiday prize draw.

Anyone who is interested in exhibiting should contact Simon Proctor or Jessica Lonnkvist at:
**Chemex.**
**Tel: 0181 742 2828.**

## Bear necessities for the kids

A new children's multi-vitamin and mineral supplement will be launched by Ultimate Health Products on stand C4.

Yummi Bears are designed to help give kids the daily nutrition they need from vegetables and fruits.

Each bear contains 100mg of natural organic wholefood concentrates, including broccoli, Brussels sprouts, cabbage, carrots, parsley, tomatoes, cauliflower, spinach, alfalfa, papayas and apples. These are blended into a base of organic unrefined cane juice, citric acid, vegetable gelatine, natural vegetable colours and natural fruit flavours.

- Health and sports-related prizes can be won in a free prize draw competition which will be running on stand C4 throughout the exhibition.

**Ultimate Health Products.**
**Tel: 0181 902 4321.**

## Pharmacy plans for sensitive eye cosmetics

Eye Care Laboratories will be introducing its range of eye cosmetics for contact lens wearers on stand N4.

Distribution for the Eye Care Cosmetics range is focused on the optical market.

Designed for sensitive skin, the products are formulated to stimulate the immune defence mechanisms of the epidermis, resulting in a slowing down of one of the major causes of cutaneous ageing.

Ingredients include langherine extract, peach-leaf extract, vitamin E micro-emulsion and a moisturising complex of plant extracts.

The range includes cream eyeshadow, fluid eye liner, pencil eye liner, mascara, eyeshadow, wrinkle cream and eye make-up remover in a milk-based emulsion or a water-based lotion. Retail prices range from £3.99 to £14.99.

**Eye Care Laboratories.**
**Tel: 01884 256456.**

## Bioconcepts works on Nightshift

Bioconcepts will be launching a night mask for problem skin on stand N24.

Called Nightshift, the product will be part of the La Formule antibacterial skin care brand for spot-prone skin.

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OLYMPIA 2 LONDON

The product is designed to 'correct' impurities and help balance the skin's pH without the drying effect often associated with topical medical treatments.

Like the other La Formule products, it is not chemically-based. Its formulation includes green clay, sweet almond oil and essential oil of geranium.

The product will retail at £4.99 for a 15ml tube which will last around seven weeks if used each night.

**Bioconcepts Ltd.**
**Tel: 01705 499133.**

## The all-natural fat absorber

A1 Pharmaceuticals will be launching Liposorb fat absorber on stand R8.

The product is made from an all-natural marine fibre which binds dietary fat and facilitates its passage through the body undigested.

Its main active ingredient is chitosan, which is extracted from the shells of selected crustaceans harvested for the New Zealand food industry.

The manufacturer claims that Liposorb is capable of absorbing 12 times its weight in fat. It is designed to allow a normal to high-fat diet to be eaten, while reducing the dietary fat being absorbed by the body.

Adults should take three to four capsules with each meal containing dietary fat. It is recommended to drink a glass of water with the capsules.

**A1 Pharmaceuticals.**
**Tel: 0171 738 7373.**

## Hair-raiser

Top hairdresser Trevor Sorbie (below), four times winner of 'British Hairdresser of the Year', will be on stand P1 to discuss his Professional Haircare range – available through Brand Managers.

- New on the same stand will be a French Art Deco bath line, called L'Aromarine. It will incorporate confetti bath leaves as well as more traditional bath and shower products.

**Brand Managers Ltd.**
**Tel: 0181 286 6688.**

## Pumping up the action

Mavala will be introducing a new pump-action liquid foundation on stand D7.

Specially developed to resist climatic variations, Mavala contains vitamin E, vitamin A palmitate, ceramides of natural origin and a UV filter.

It is formulated with a light texture to provide a uniform tint, helping to make irregularities and blemishes more inconspicuous.

Presented in a glass bottle (30ml) with measuring pump, it will retail at £13.35.

**Mavala UK Ltd.**
**Tel: 01732 459412.**

## NPA savers

**There will be a chance to save on numerous items at the National Pharmaceutical Association's business services display on stand K24. Pharmacy planning department consultants will also be on hand to discuss any ideas you may have for improving your pharmacy.**

**NPA.**
**Tel: 01727 842161.**

## PRS hot news

**Practice Resource Systems has a major announcement planned for Chemex. It will also be running a special exhibition offer on stand G1.**

**Practice Resource Systems.**
**Tel: 01793 526777.**

## Read all about it

**New titles from Sheldon Press on stand T2 will include 'Living with a Stoma', 'Coping with Fibroids', and 'Coping with Coeliac Disease'.**

**Sheldon Press.**
**Tel: 0171 387 5282.**

# Taming the stock monster

**Pharmacists all over the country are losing out financially because of poor stock control. Wilf Altman explains how to reverse this trend**

Stock represents money. If the extra profit on that bonus parcel is not greater than the interest you could obtain from a building society, the extra money tied up would be better invested elsewhere ... Wise words from the National Pharmaceutical Association, yet how many pharmacists heed them?

One management consultant believes many pharmacists are grossly overstocked because their control systems are too poor. If that stock is allowed to build up, it could affect your profits. Stock worth £90,000, for example, is a sizeable investment that quickly becomes a financial burden if it is not moving, as the anonymous pharmacist found to his cost in *C&D*'s **Business in Focus** (April 19, p26).

One week's stock should be sufficient because it allows you to meet changing trends. Well advertised, established brands remain best-sellers, but you have to give space to the latest, most heavily-promoted lines because customers ask for them. Result: slow movers tend to move even more slowly.

Another problem in carrying too much stock is that it clutters up stockroom space and takes up staff time as they search for lines to replenish shelves.

Why keep stock stored away? Only the biggest retailers, buying and selling huge quantities, can afford this. And with daily deliveries from central warehouses, even they are storing less.

If you have got storage space behind the pharmacy, why not extend your outlet and put everything up for sale? It makes business sense to increase your selling space and range, especially if you are working in a cramped pharmacy with limited ranges and barely space for customers to browse and shop in comfort.

Extending the shop, giving it a fresh coat of paint and rearranging shelves at the same time should help. Stripping a dividing wall and converting that storeroom behind as part of the shop may cost you between £8,000 and £10,000, including a bit of a facelift for the rest of the store. If you can make a re-opening splash, offering some interesting 'specials', you could be pleasantly surprised by the results.

Plan your new product ranges carefully. It's easy to fall for unusual lines if a salesman gives you a persuasive pitch dotted with 'fantastic deals on offer'.

A key lesson in stock and space management is to insist on handling all the buying yourself. You cannot blame anyone else, then, if that special offer turns out to be a bit of a dud, or if the line fails to budge despite quantity price discounts.

Talk to your customers – they are your best source of market research when it comes to deciding which new lines to stock. Then ensure, as far as possible, that you concentrate on lines with the maximum gross profit.

Make sure that the new line does not lose its value, especially if you are selling those with a 'sell by' date, and be vigilant as far as pilferage is concerned. Some customers, staff and delivery drivers could be tempted if you show the slightest laxity.

So how can you spice up your selling space? Take a fresh look at every square foot. If you are concentrating on four or five ranges, inject some promotional excitement into each, introduce additional ranges and new lines (especially some that large stores don't stock), make good use of your shop window and make each square foot really sell.

Another alternative is to join a buying group, which passes on to members the benefits of significant buying power.

In an ideal world, getting special benefits for paying cash can pay dividends, but, unless you can sell the stock fast, by passing on some of the benefits of having bought for immediate cash, there are few tangible benefits, especially if storage is necessary.

Make sure you have the right product 'mix' – supermarkets and large pharmacy chains already do.

You could, of course, invest in an EPoS system. That would improve your stock control, providing you use the data wisely.

EPoS is effective, but it can be expensive. If you want a cut-priced stock control system, the NPA provides stock control cards, which are part of its business management material. How you use them depends on the size of your business, the way you buy and keep your stock. A pack of 200 cards is £9.50 and the NPA can also give you a set of dividers to keep a card index.

Trefor Williams, the NPA's business services manager, says it is a simple procedure, but you have to take into account seasonal variations. The more frequently you count, the lower your stock level is likely to be.

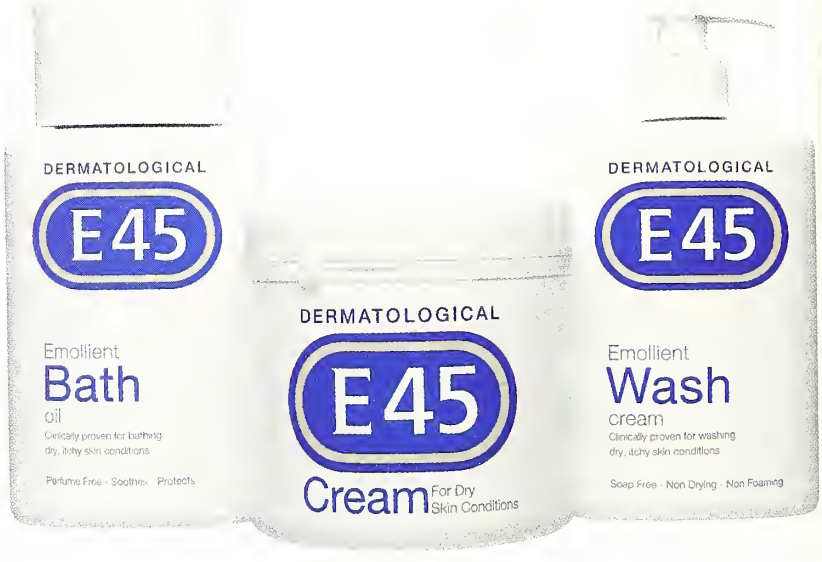
"But it's a tedious, time-consuming and routine task, like filling up the shelves – so it's ideal for a responsible member of staff," he says.

If you do not want cards, he says, you can always "develop your own stock and ordering system, but, whatever you use, stick to it. Don't guess".

# She's had eczema her whole life.

## But now she has E45 Complete Emollient Therapy

It's no fun going to school with eczema – it's hard work.
But it needn't be with a daily management regime.
That's why she bathes everyday in E45 Bath –
an unperfumed bath oil. That's why she washes every time
with E45 Wash – a non-drying soap-substitute.
And that's why she applies E45 Cream whenever she needs to.
E45 offers a unique emollient management
programme that is specifically tailored to meet the needs
of patients with dry eczema and is both effective and
pleasant to use. It's ideal for your recommendation.
That's why she uses E45 Complete Emollient Therapy.




DERMATOLOGICAL E45 Complete Emollient Therapy™

**Prescribing Information**
**E45 Cream**
White, smooth emollient cream which contains White Soft Paraffin BP 14.5% w/w, Light Liquid Paraffin Ph Eur 12.6% w/w, and Hypoallergenic Anhydrous Lanolin 1.0% w/w.
**Uses**
For the symptomatic relief of dry skin conditions where the use of an emollient is indicated, such as flaking, chapped skin, ichthyosis, traumatic dermatitis, sunburn, the dry stage of eczema and certain dry cases of psoriasis.
**Dosage and Administration**
Apply to the affected part two or three times daily.
**Contra-indications, Warnings etc**
E45 Cream should not be used by patients who are sensitive to any of the ingredients.
**Package Quantities**
Tubes containing 50g. Tubs containing 125g and also 500g.

**Basic NHS Cost**
50g £1.18, 125g £2.39, 500g £5.61.
**Legal Category:** GSL
**Product Licence Number**
PL0327/5904
**Product Licence Holder**
Crookes Healthcare Ltd, Nottingham NG2 3AA
**Date of preparation**
February 1997

**E45 Emollient Wash cream**
**E45 Emollient Bath oil**
Further information is available on request from Crookes Healthcare Ltd, Nottingham NG2 3AA.
**Legal Category**
ACBS
**Date of Preparation**
February 1997

# PHARMACY update



# Brittle and twisted

**Osteoporosis is no longer a disease of 'little old ladies'. Men can be victims, too. Adrienne de Mont looks at current thinking on prevention and treatment in all vulnerable groups**

Every three and a half minutes someone in the UK has a fracture as a result of osteoporosis. Forty people die from these fractures each day.

The National Osteoporosis Society estimates that one in three women and at least one in 12 men are affected by this painful, debilitating condition. Most cases can be prevented or treated, yet the NOS says that over 90 per cent of sufferers receive no treatment.

Osteoporosis literally means 'porous bones'. The skeleton becomes so fragile that bones break after the slightest bump or fall. A fracture is often the first sign that anything is wrong.

Another indication is a marked curve in the upper back – the so-called 'dowager's hump' – and loss in height due to bones in the spinal column being crushed. Backache is common.

National Osteoporosis Society

So-called 'dowager's hump' results from crushed bones in the spine

## Pathophysiology

A child's skeleton is replaced, cell by cell, every two years. An adult's takes seven to ten years to replace.

Bones of the arms, legs and spine have an outer layer of dense, compact cortical bone and an inner honeycomb structure of trabecular bone.

The bones stop growing in length between the ages of 16-18 years, but continue to increase in density until peak mass occurs at about 30. This phase is known as modelling, during which mineralisation or impregnation with calcium occurs. A calcium-rich diet and exercise are important in childhood, adolescence and early adulthood to maximise bone mass and strength.

Bone strength and density start to deteriorate from about 35 years old. The osteoclasts, which resorb old bone, start to become more active than the osteoblasts which deposit new bone. The rate of rebuilding fails to keep up with the rate of breakdown, resulting in osteoporosis. Large gaps appear in the trabecular bone as the honeycomb structure crumbles. The denser cortical bone is also affected.

Women are more at risk than men as they have smaller skeletons. They experience a five to ten-year period of rapid bone loss at the menopause due to a fall in oestrogen levels. This is followed by a less rapid phase of age-related bone loss which men also experience.

**THE COLLEGE OF PHARMACY PRACTICE**

THIS COURSE (MODULE 59), IN ASSOCIATION WITH MULTIPLE CHOICE QUESTIONS BEING PUBLISHED IN *C&D* AUGUST 9, PROVIDES 1 HOUR OF CONTINUING EDUCATION

## OBJECTIVES

- To be familiar with the pathophysiology of the disease
- To be aware of preventative measures to avoid disease
- To be familiar with the drug treatments available
- To understand the implication of risk factors
- To be aware of the daily calcium intake requirements

## Screening

Men and women who have already had a fracture after a minor fall are at risk of having another one. Back pain, particularly acute pain lasting for six to eight weeks in the over-50s, and height loss are also causes for concern.

People worried about a risk of osteoporosis should be referred to a GP who might recommend a bone density measurement, helping both the doctor and patient to decide whether to prescribe or take preventative therapy.

Dual X-ray absorptiometry (DXA) is the most widely used method of assessing bone mineral density. The scan involves a dual energy X-ray beam at a radiation dose less than natural daily background radiation. It is usually used for measuring bone mineral density in the hip or spine, and can be used to measure the total skeleton.

Another means of assessing fracture risk in

*Continued on PII* ▶

◀ Continued from PI

those over 75 is by ultrasound densitometry of the heel, but in general this is considered to be less reliable.

A private scan can cost from £25-£450, with an average around £70. The NOS can provide more information on availability.

## Prevention

Diet, exercise and lifestyle are key factors in preventing osteoporosis from childhood.

**Calcium**

The NOS recommends daily intakes of calcium (see Box 1) which are higher than the RDA. Milk and dairy products are the best sources of calcium, and low-fat varieties generally contain as much or more.

Although diet is the best way to ensure adequate calcium intake, supplements may be needed by:

- women who are pregnant, breastfeeding or over 45
- teenage girls who miss meals or who cut out calcium-rich foods in the belief they are 'fattening'
- strict vegans
- people with lactose intolerance, coeliac disease or malabsorption problems.

When advising on calcium supplements, pharmacists should take into account a person's dietary intake so as not to exceed 2g daily. They need to be aware how much elemental calcium a supplement contains, as with some preparations it may be necessary to take six to eight tablets a day to achieve the required amount.

**Vitamin D**

Vitamin D helps the body to absorb calcium and regulates bone resorption. The best natural sources are sunlight and oily fish. Production of vitamin D by the action of sunlight on the skin decreases with age, so elderly people who are unable to get out much may need calcium and vitamin D supplements.

Again, pharmacists need to assess a person's dietary intake before recommending supplements. The therapeutic window recommended by the NOS is 400-800iu a day, which should not be exceeded.

**Magnesium**

Recent research suggests that magnesium might also be important, as women with low dietary intakes have lower bone mineral densities.

**Exercise**

Exercise is also beneficial throughout life. Studies have shown that weight-bearing exercise for about 30 minutes two or three times a week strengthens the bones and there is evidence that lack of exercise significantly increases the rate of bone loss. If elderly people can only take moderate exercise, this is still useful in improving balance and co-ordination.

Joan Bassey, Queen's Medical Centre, Nottingham, has reviewed various exercise programmes and their effects on bone mineral density (*Osteoporosis Review 1996; 4:1; 3-4*). She recommends high-impact activity such as jogging or jumping, done in brief bouts to minimise the risk of over-use injury.

Brisk walking can strengthen the hip as well as the legs. Swimming is a low-impact activity because of the cushioning effect of the water, so it does not increase bone density, although it helps to strengthen the muscles after a fracture.

People who have had a fracture should start with gentle exercise as soon as the fracture has healed, gradually building up to three sessions a week.

**Lifestyle measures**

Other lifestyle advice includes giving up smoking and limiting alcohol intake to the recommended safe amounts (28 units a week for men and 21 for women). Something to consider in elderly people is whether medication is likely to cause drowsiness or dizziness which might make them more prone to falls.

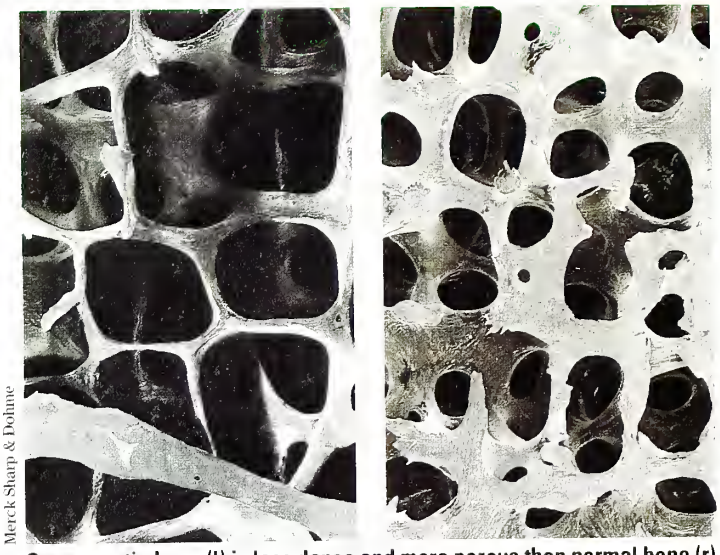
## Drug treatment

For individuals at high risk of osteoporosis, lifestyle measures are not enough and drug treatment is indicated. Hormone replacement therapy is still considered to be the best way to prevent osteoporosis in post-menopausal women. Oestrogen protects bone against the resorbing actions of the parathyroid hormone. Studies have shown women who use HRT for at least five years, starting soon after the menopause, reduce the risk of fracture by about 60 per cent.

But not all women need it. A bone scan can estimate the degree of risk by comparing mineral density with the average measurements for people in the same age group.

The bisphosphonate etidronate has recently been licensed for the prevention of all common forms of osteoporosis in men and women, including corticosteroid-induced disease, so this is now another option for women unable to take HRT.

There is no consensus as to when preventive treatment should start in people taking corticosteroids, and consultants may wish to do a bone scan before deciding. More than 7.5mg a day of prednisolone daily for more than six months is generally considered as 'high-dose, long-term' treatment.



Merck Sharp & Dohme

**Osteoporotic bone (l) is less dense and more porous than normal bone (r)**

**Box 1: risk factors**

- **The menopause.** Women who have an early menopause (before 45) or hysterectomy before the menopause are especially at risk, particularly if an ovary is removed.
- **Long-term, high-dose treatment with oral corticosteroids.** These drugs impair calcium absorption from the gut, increase calcium excretion, decrease steroid production, reduce bone formation and increase bone resorption.
- **Over-rigorous dieting regimes, anorexia or bulimia nervosa.** These can result in low calcium intake and amenorrhoea.
- **Over-intensive exercise.** This is a problem in young athletes, dancers, etc, particularly if their hormonal balance is upset by not eating enough to compensate for their high energy output. Amenorrhoea for six months or more could be a warning sign of low oestrogen levels.
- **Heavy smoking or drinking.** Alcohol interferes with calcium absorption, while tobacco reduces oestrogen levels and may lead to an early menopause.
- **Strong family history** – for example, mother with hip fracture.
- **Chronic disease,** such as liver hyperparathyroidism, thyrotoxicosis, malabsorption, rheumatoid arthritis, myeloma, hypogonadism.
- **Prolonged periods of inactivity.** This has been experienced by astronauts and people confined to bed for a long time.

## 1 Hormone replacement therapy

To prevent further bone loss, women under 65 are likely to be prescribed HRT. Women over 65 can still take it but may prefer alternatives because of problems such as bleeding, breast tenderness and weight gain.

Women with an intact uterus should receive oestrogen plus progestogen to avoid the slightly increased risk of uterine cancer associated with long-term oestrogen use.

Women who are at least one year post-menopause may prefer combined preparations which are taken continuously. Tibolone, which is period-free, was recently licensed for prevention of post-menopausal osteoporosis.

Women for whom HRT might not be suitable include those with a history of thrombosis, high blood pressure, diabetes, migraine, a history of breast cancer or breast cancer in close family, and heavy smokers.

In risk:benefit terms, HRT is still considered to be the best treatment for post-menopausal osteoporosis.

## 2 Bisphosphonates

The bisphosphonates disodium etidronate and alendronate sodium reduce bone resorption by inhibiting the osteoclasts.

Continued on PIV ▶

OMIG'

**onsult Summary of Product haracteristics before prescribing. pecial reporting to the CSM quired.**

**se** Acute treatment of migraine with without aura.

**resentation** Tablets containing 2.5mg zolmitriptan.

**osage and Administration** The commended dose of 'Zomig' to treat migraine attack is 2.5mg.

symptoms persist or return within 4 hours, a second dose has been own to be effective. If a second dose required, it should not be taken within hours of the initial dose.

satisfactory relief is not achieved, ubsequent attacks can be treated with mg doses.

patients who respond, significant fficacy is apparent within 1 hour of osing.

the event of recurrent attacks, it is ecommended that the total intake of Zomig' in a 24 hour period should not xceed 15mg.

Zomig' is not indicated for prophylaxis f migraine.

afety and efficacy of 'Zomig' in aediatrics, adults over the age of 65 nd patients with hepatic impairment ave yet to be established.

**Contra-indications** Hypersensitivity o any component of 'Zomig' and ncontrolled hypertension.

**Precautions** A clear diagnosis of migraine must be established. Care hould be taken to exclude other otentially serious neurological conditions. No data in hemiplegic or asilar migraine.

Zomig' should not be given to patients with Wolff-Parkinson-White syndrome or arrhythmias associated with other cardiac accessory conduction pathways. Zomig' is not recommended in patients with ischaemic heart disease. In patients n whom unrecognised coronary artery disease is likely, cardiovascular evaluation prior to commencement of treatment is recommended.

As with other $5HT_{1D}$ agonists, atypical sensations over the precordium have been reported after administration of 'Zomig' but in clinical trials these have not been associated with arrhythmias or ischaemic changes on ECG 'Zomig' may cause mild transient increases in blood pressure.

Patients should leave at least 6 hours between taking an ergotamine preparation and starting 'Zomig' and vice versa. Concomitant administration of other $5HT_{1D}$ agonists within 12 hours of 'Zomig' treatment should be avoided. A maximum intake of 7.5mg of 'Zomig' in 24 hours is recommended in patients taking a MAO-A inhibitor. Caution in pregnancy and breast-feeding. Use is unlikely to result in an impairment of the ability to drive or operate machinery However, somnolence may occur.

**Undesirable Effects** Nausea, dizziness, somnolence, warm sensation, asthenia and dry mouth have been the most commonly reported.

Abnormalities or disturbances of sensation have been reported; heaviness, tightness or pressure may occur in the throat, neck, limbs and chest (no evidence of ischaemic ECG changes), as may myalgia, muscle weakness, paraesthesia, dysaesthesia.

**Legal Category** POM.

**Product Licence Number** 12619/0116.

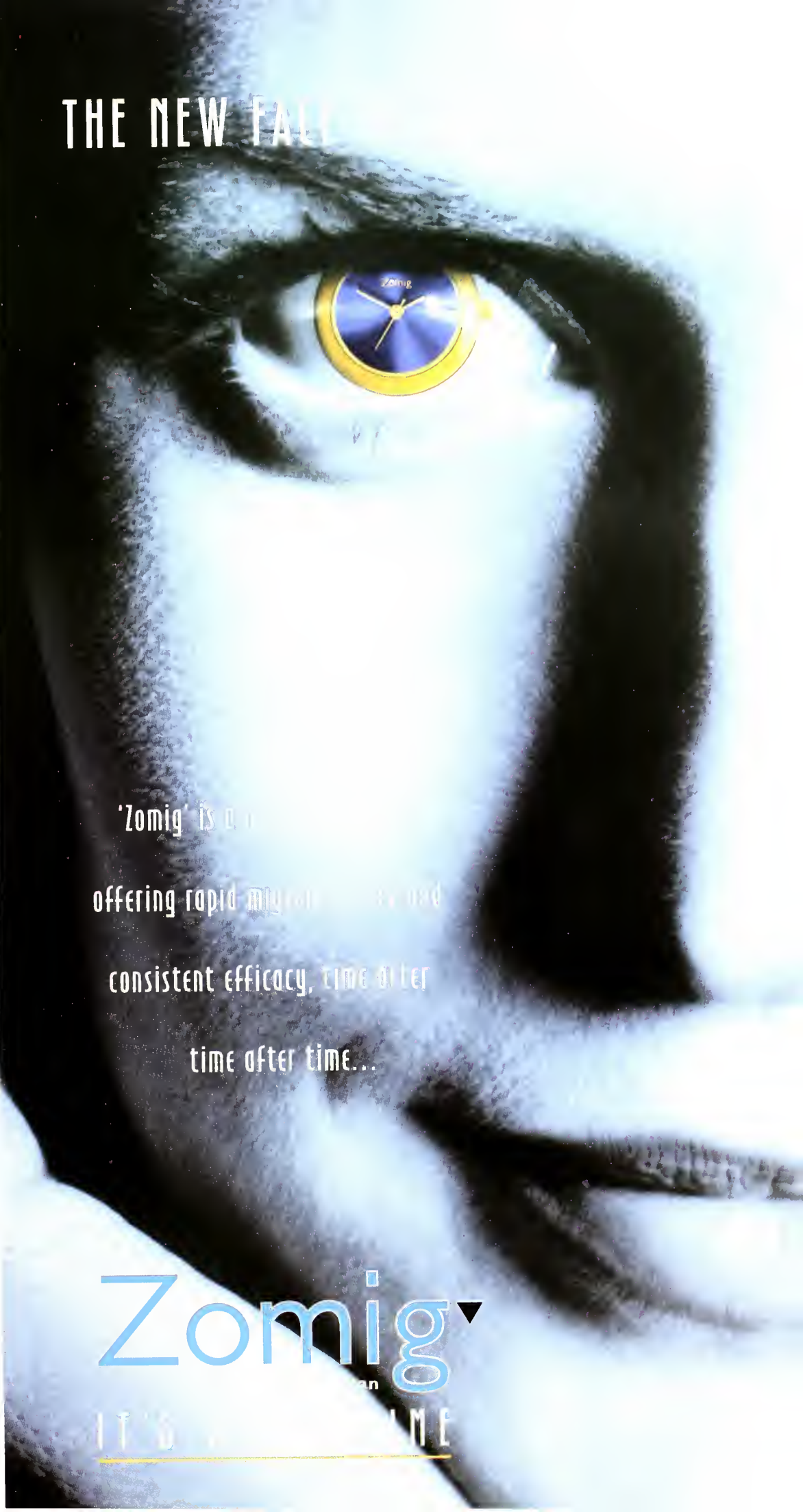
**Basic NHS Cost** 3 tablet pack (2.5mg) £12.00. 6 tablet pack (2.5mg) with wallet £24.00.

**'Zomig' is a trademark of the Zeneca group of companies.**

Further information is available from: ZENECA Pharma, King's Court, Water Lane, Wilmslow, Cheshire SK9 5AZ.

97/7590/K Issued March 1997

ZENECA



Men are also at risk. Before ...

... and after

National Osteoporosis Society

◀ *Continued from PII*

Trials have shown that bisphosphonates improve bone mass over two to three years. A 50 per cent decrease in spinal fractures is similar to that seen with HRT and calcitonin. A study of cyclical etidronate showed up to 88 per cent reduction in vertebral fractures in the second and third year of treatment of post-menopausal women.

Bisphosphonates can be used by women ten to 15 years after the menopause, although intervention is best during the initial rapid phase of bone loss.

Didronel PMO is taken as a 90-day cycle of etidronate for two weeks followed by a calcium supplement for 76 days, which aids mineralisation of newly-formed bone. Etidronate is given in cycles to prevent impairment of bone mineralisation, although studies have shown it is well tolerated and effective for up to seven years.

Previously approved only for established vertebral osteoporosis, Didronel PMO is licensed for the treatment of osteoporosis at all sites, including the hip. It is also the only treatment licensed specifically for corticosteroid-induced osteoporosis.

Etidronate must be taken two hours before or two hours after food, with water or fruit juice. Milk, other calcium-containing products and iron supplements inhibit absorption. It may cause nausea, as might the Cacit supplement, and diarrhoea.

Alendronate is licensed for the treatment of post-menopausal osteoporosis, at all sites, in post-menopausal women. It is taken continuously on a daily basis. It has been associated with severe oesophageal irritation and should be used with care in people prone to ulcers or heartburn. The tablets should be swallowed whole with a glass of water 30 minutes before breakfast, with the patient standing or sitting upright for at least 30 minutes afterwards.

## 3 Calcium and vitamin D

Studies in the elderly have shown that calcium supplements can reduce the risk of a vertebral fracture by 20 per cent, and that calcium and vitamin D supplements may reduce the risk of hip fracture by 30-40 per cent. Calcium supplementation around the menopause has some benefit on bone density, although not as much as oestrogen replacement.

Calcium can irritate the gastro-intestinal mucosa and should be used with care in patients with ulceration. It can accentuate the effects of digoxin and other cardiac glycosides.

Vitamin D2 (ergocalciferol) and vitamin D3 (cholecalciferol) increase bone mass and reduce fracture incidence.

Calcitriol is a hydroxylated vitamin D derivative which is licensed for post-menopausal osteoporosis. It may cause hypercalcaemia and hypercalciuria and should not be taken at the same time as other vitamin D supplements.

## 4 Calcitonin

Calcitonin, released by the thyroid, briefly inhibits bone resorption by osteoclasts. It is involved with parathyroid hormone in the maintenance of calcium balance.

Calcitonin increases bone mineral density, particularly in the spine, and there is evidence it reduces hip and vertebral fracture rates. It also reduces the pain of spinal crush fractures. It is given by injection, but an oral form is under clinical trial. Prolonged use of pork calcitonin can lead to the production of neutralising antibodies.

Salcatonin is a synthetic form of calcitonin, licensed for established post-menopausal osteoporosis. Given by injection, it is regarded as most suitable for patients who cannot take HRT or bisphosphonates. Clinical trials have shown an increase in bone density after two years, a 30 per cent reduction in new fractures and 60 per cent in crush fractures.

It is believed to inhibit the calcium pump that transports calcium out of bone cells into the extracellular space. Patients should also take 600mg elemental calcium and 400 units of vitamin D daily.

Adverse reactions to calcitonins include nausea, vomiting, flushing and tingling hands.

## 5 Anabolic steroids

Nandrolone decanoate is restricted to very frail, elderly patients with severe osteoporosis or who have a very rapid rate of bone loss. It stimulates new bone formation, inhibits resorption, enhances calcium absorption and relieves pain. Disadvantages are androgenic effects such as hair growth, acne and voice lowering, as well as nausea, dizziness, rashes, headache, backache and nervousness.

## 6 Testosterone

In men, testosterone may be used to increase bone density in hypogonadal osteoporosis. There is also evidence testosterone injection may be effective for some men with normal natural levels.

## X Y Z Treatment choice

In a review of drug treatments (*Ann Rheum Diseases 1996;55;700-714*), Dr Sanjeev Patel, Department of Rheumatology, St George's Hospital, London, says that long-term oestrogens are still the mainstay of treatment but the risks of breast cancer versus the cardiovascular and skeletal benefits have to be assessed in each individual. When HRT is inappropriate or unacceptable, bisphosphonates should probably be considered next.

**Box 2: the NOS-recommended daily calcium intake**

- **Children 7-12 years, 800mg**
- **Teenagers 13-19, adult males, females 20-45 and those over 45 on HRT, 1,000mg**
- **Pregnant and nursing women, 1,200mg**
- **Pregnant and nursing teenagers, women over 45, 1,500mg**

## ACTION PLAN

**1** In your practice workbook list the various preparations used to treat osteoporosis. Note their mode of action, dosage and the counselling instructions you need to provide.

**2** For the next ten cases of fractures in the elderly, record in your practice workbook the sex of the patient, the site of fracture, its causes and whether the patient is taking any preparations to combat osteoporosis.

**3** Write a brief outline of how you would counsel a 50-year-old man who is concerned about the possibility of suffering from osteoporosis.

[Since the article, etidronate has become the only option for corticosteroid-induced osteoporosis].

Calcium supplementation, or an increase in dietary intake if deficient, irrespective of what agent is used, is also of benefit, says Dr Patel.

Calcitriol is best considered as a third-line agent and reserved for specialist use, possibly in patients with renal impairment where vitamin D may not be effective or where there is intolerance to bisphosphonates, says Dr Patel. Calcitonin could also be used as a third-line agent under specialist supervision.

Combination treatment, for example, with oestrogens, bisphosphonates and calcium, may be "an attractive option" in younger patients with higher bone turnover.

*C&D is accredited by the College of Pharmacy Practice as a provider of distance learning material until December, 1997.*

**Resources**


- The National Osteoporosis Society, PO Box 10, Radstock, Bath BA3 3YB. Tel: 01761 471771. The NOS has a wide range of consumer and professional literature on the prevention and treatment of osteoporosis.

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escribing information for Dovonex eam/Dovonex Ointment and Dovonex alp Solution. Presentation: Dovonex Cream ntains 50 micrograms calcipotriol per g (as hydrate). Dovonex Ointment contains 50 crograms calcipotriol per g. Dovonex Scalp lution contains 50 micrograms calcipotriol per Indications: Cream/Ointment: Treatment of ld to moderate plaque psoriasis affecting up to 0% of skin area. Scalp Solution: Topical atment of scalp psoriasis. Dosage and dministration: Apply twice daily to the fected areas. Maximum weekly dose should t exceed 100g of Cream or Ointment or 60ml alp Solution. Not recommended in children or egnancy as there is no experience of use. hen Dovonex Scalp Solution is used together th Dovonex Cream or Ointment, the total dose calcipotriol should not exceed 5mg in any eek e.g. 60ml Scalp Solution plus one 30g be of Cream or Ointment, or 30ml Scalp lution plus 60g (two 30g tubes) of Cream or intment. Contra-indications: Patients with own calcium metabolism disorders. ypersensitivity to any constituents. Precautions: hould not be used on the face. Wash hands ter application. Avoid inadvertent transfer to Drug Interactions Side Effects: Cream/Ointment: irritation and localised reactions. Reactions reported with include dermatitis aggravation of psoriasis, and rarely hypercalcaemia or Solution as above. In addition the scalp or face may Use during pregnancy and lactation: human pregnancy has not yet been established although studies in experimental animals have not shown teratogenic effect. pregnancy unless there is no safer alternative is not known whether calcipotriol is excreted in breast milk. Overdose: Hypercalcaemia may occur in patients with plaque psoriasis who use

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L E O

# A run-in with diarrhoea

THE COLLEGE OF PHARMACY PRACTICE

THIS COURSE (MODULE 60), IN ASSOCIATION WITH MULTIPLE CHOICE QUESTIONS BEING PUBLISHED IN *C&D* AUGUST 9, PROVIDES 1 HOUR OF CONTINUING EDUCATION

**Diarrhoea can hit when it is least expected, leaving the sufferer embarrassed and distressed. Derek Balon, community pharmacist and King's College lecturer, discusses how these patients can be saved from dire straits**

## OBJECTIVES

- To be familiar with the pathophysiology of diarrhoea
- To be aware of the causes of diarrhoea
- To diagnose diarrhoea using the mnemonic SCRUTINY
- To be aware of drug and non-drug management of diarrhoea

Diarrhoea may be defined as the more frequent passing of stools, which are more fluid than usual. It should be noted that this definition reflects a significant change from normal. The fluidity is important: stools contain about 100-200ml of fluid; in a patient with severe diarrhoea this can increase to 10 litres in 24 hours.


## Incidence

It is difficult to obtain accurate figures for the incidence of all self-limiting minor conditions, as most surveys are the result of self-reporting. However, 19 per cent of respondents to a British survey reported diarrhoea in the last year and 4 per cent in the previous two weeks.

## Pathophysiology

There are four major pathophysiological mechanisms which result in diarrhoea (see Table I).

In the normal gut, the balance between absorption and secretion of fluids is maintained. Diarrhoea is the result of a significant change in this balance, favouring excess fluid reaching the lower colon. Ion-transport mechanisms are the primary regulators of this balance, which act in conjunction with various hormones (vasopressin, glucocorticoids) and some neurotransmitters (serotonin). Various diseases affect these regulators which result in diarrhoea. Drugs may act directly (altering osmolarity) or indirectly (antibiotics allowing overgrowth of toxin-producing bacteria) giving rise to diarrhoea.

**Table I: classification of diarrhoea**

| Type | Mechanism | Example of cause |
|---|---|---|
| Osmotic | decreased absorption of fluids from the gut | lactase insufficiency, excess sorbitol ingestion |
| Secretory | increased secretion | toxins produced by bacteria |
| Exudation | excessive exudation | ulcerative colitis, Shigella infection |
| Motility | motility change | irritable bowel syndrome |

## Causes

Diarrhoea can be either acute or chronic. Chronic diarrhoea is defined as diarrhoea of more than four weeks standing and is outside the remit of community pharmacists: such patients must be referred to their general practitioner for assessment.

Acute diarrhoea is often caused by bacteria and viruses. In children, the most common causative organism is viral. Two viruses are implicated: the rotavirus in infants and children (six to 24 months old); the Norwalk virus in adults.

'Food poisoning', a term used to describe the condition which results from pathogenic bacteria ingested with food, is common for adults, as is dietary indiscretion. The bacteria which cause diarrhoea may be classified into non-invasive and invasive: non-invasive bacteria do not damage gut mucosa directly but produce exotoxins which interfere with the normal secretory/absorption process. Invasive bacteria directly attack mucosal cells which causes the diarrhoea; stools from such an attack may contain blood and pus.

The mechanism of virally-induced diarrhoea is not fully understood, but is believed that the normally absorptive intestinal lining becomes secretory, resulting in excess water in the colon. Some protozoa and fungi also cause diarrhoea.

Some drugs cause diarrhoea, most notably antibiotics (especially clindamycin). Antibiotic-associated diarrhoea (AAD) is usually the result of an overgrowth of an antibiotic-resistant bacteria or fungi which produces toxins. Other drugs implicated include those in Table II.

## Presentation

The presentation of diarrhoea is usually straightforward. The only problem normally encountered is the patient's embarrassment to talk about the subject.

**Questions to ask:**

- describe the stool – formed or watery
- how often do you pass a stool?
- how long have you had these symptoms?
- was the onset sudden?

**Table II: drugs implicated in causing diarrhoea**

| | |
|---|---|
| Antibiotics | can start as long as four weeks after drug course |
| Laxatives | abuse: inappropriate dosage: magnesium salts |
| Chemotherapeutic agents | |
| Mefenamic acid | |
| Antacids | magnesium-containing |
| Misoprostol | |
| Colchicine | not in general use nowadays |
| Digoxin | |
| Methyldopa | |

- any blood or mucus in the stool?
- any other symptoms?
- anyone else with this problem?
- any questionable food/alcohol excess recently?
- have you been abroad within the last week?
- what about medicines/drugs?
- age?

## Diagnosis

Pharmacists should not treat chronic diarrhoea and should be wary of treating acute diarrhoea of more than 24 hours' duration. The following refers only to acute diarrhoea.

- **Symptom complex**

Acute diarrhoea is characterised by its rapid onset, which may be accompanied by gastric cramp, stomach pains, colonic pain, flatulence, nausea and vomiting, and occasionally pyrexia. Formed stool is not often present in patients with true diarrhoea, although at the start of an attack stool may be mixed or only semi-formed. The presence of blood or mucus in the stool requires referral as does a temperature (>38°C) or any signs of dehydration (loss of skin turgor). Pyrexia is more common with invasive bacterial attack.

- **Region**

Self-explanatory: the passing of stool. Pains associated with this condition can be either in the upper or lower region of the intestine or both.

- **Universal factors**

Common causes of diarrhoea include 'bad' or unusual food, alcohol, drugs and contaminated water, especially for those who have travelled abroad. In the case of 'food poisoning', others who ate the same food may have a similar problem.

*Provoking factors:* one of the most commonly encountered causes of diarrhoea in community pharmacy is bacteria. Foods which are unusual for the patient may cause the problem as may spicy meals or alcohol excess.

*Relieving factors:* self-treatment by having no food will, in the majority of cases, reduce the diarrhoea to a point at which it will cease (self-limited condition). In the more severe cases, drug treatment is required.

- **Time/intensity**

Dehydration is the major risk to patients so the time/intensity continuum has to reflect this. Loss of fluid in the stool may be considerable. The passing of loose watery stools for more than 24 hours may be serious and such patients should be referred. Less severe water loss over a period of two to three days also requires referral.

- **Natural history**

Attacks often start with griping stomach and/or lower colon pains. Diarrhoea follows, frequently with the initial stool formed (absorption from the gut being normal when this was formed). Subsequently, the stool becomes unstructured and watery. Some gas may be passed. Nausea and vomiting may occur, especially with infectious bacterial attack.

- **Your current medication**

See Table II.

## Management

Attention has already been drawn to the fact that only acute diarrhoea should be treated by the pharmacist: chronic cases should be referred. Once again CARE should be taken.

- **Chronic/risk group/age**

Infants are always at risk from diarrhoea and such patients should only be treated by advising rehydration therapy and referral.

The elderly should also be cautiously assessed. They frequently have other chronic conditions which raise management risks, especially diabetics and those with heart disease (ion balance problems).

- **Allergies**

This does not normally create any problems.

- **Reaction of proposed medication**

The use of anti-diarrhoeal agents, if used for any length of time, may produce constipation.

- **Establish patient preference**

The best treatment for most acute diarrhoea cases seen by pharmacists is to allow it to take its natural course (non-suppression), perhaps with the use of rehydration therapy. Patients may find this socially awkward. Furthermore, they find the act of passing stool uncomfortable and disagreeable.

## Non-drug approach

The objectives of management are:

- prevent dehydration
- relief of symptoms
- identify and remove causation.

Relief of the symptoms may not be the best course of action. Many acute diarrhoeas are self-limiting and non-intervention may be the most suitable management course.

Acute bacterial diarrhoea should be allowed to run its course (24-48 hours maximum) – no food for at least 24 hours.

The American Academy of Pediatrics recommends that babies fed on breast milk may be allowed to continue after rehydration.

Drug-induced diarrhoea requires identification of the causative agents and its removal, if appropriate.

Protozoal diarrhoeas must be identified and a suitable treatment to eradicate the invading organism should be instituted (by the doctor).

Food/alcohol-induced diarrhoea requires abstinence from the offending substance and time for the intestine to recover.



## Product selection

If there is a clear indication that drugs should be employed, there are two major product classes to be considered: anti-peristaltic and rehydration agents.

- Anti-peristaltic agents: the opiates, especially codeine used to be used. Loperamide is now the drug of choice. It reduces gastric motility and produces positive water and electrolyte movement. It also reduces cramp.
- Rehydration preparations: the councils of perfection suggest that rehydration therapy should be employed, even for normal adults. Such preparations replace lost electrolytes and the glucose present provides energy and promotes electrolyte absorption.
- Antispasmodics: (eg alverine) do little to reduce diarrhoea but may reduce cramp.
- Absorbents: (eg kaolin) have little effect.

C&D *is accredited by the College of Pharmacy Practice as a provider of distance learning material until December, 1997.*

## ACTION PLAN

1 Record in your practice workbook the possible cause of the next ten cases of diarrhoea presented in the pharmacy. Identify some general advice on avoiding future attacks.

2 For each cause of diarrhoea can you select a suitable remedy or is treatment patient-specific?

3 Attempt to draw up an easy reference guide on diarrhoea causes and treatments for your pharmacy assistants.

4 For the next ten sales of electrolyte replacement salts, record the reasons behind the purchase. How valuable is such therapy in general community practice?

## PHARMACYupdate: distance learning for pharmacists

Pharmacists using **Pharmacy Update** for continuing education are reminded of the need to test. *C&D*'s readers can self-test their progress by using the multiple choice question (MCQ) paper to be inserted in the August 9 issue, which will cover this week's CPP-accredited modules, together with those in the July 19 issue.

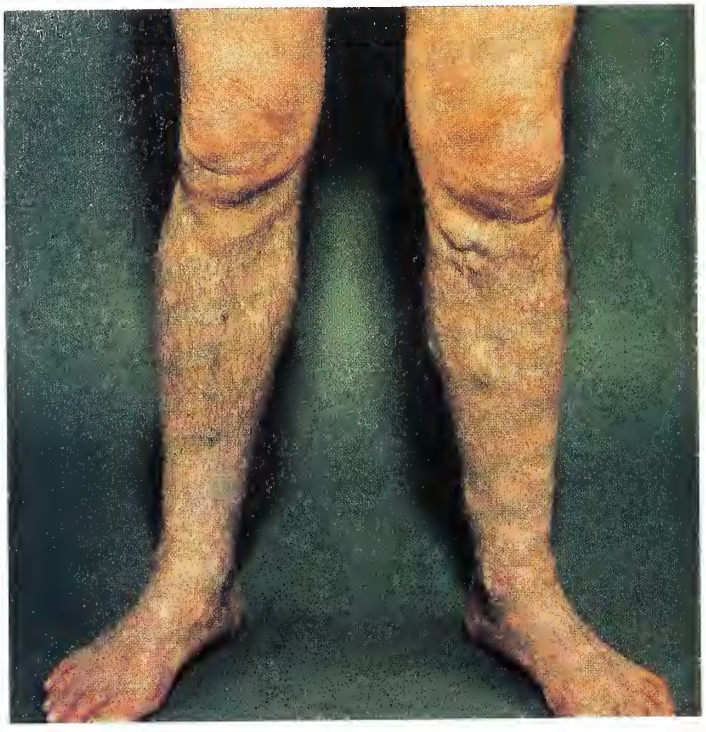
The MCQ paper for the June modules will be enclosed in next week's *C&D* covering:

- Anaemia (55)
- Nausea & vomiting (56)
- Aspirin (57)
- Breast care (58).

A faxback service for these modules and associated MCQs operates on 0891 444791 (premium rates apply).

A telephone marking service offers independent verification of results – details are given on the monthly MCQ papers.

# Vein hopes



Scholl Consumer Products

**NHS compression hosiery**

| Compression value | Class | Style | Features and benefits |
|---|---|---|---|
| 14-17mmHg | Class I | Below knee, Thigh length | Light compression for superficial or early varices or mild oedema. Prophylaxis and treatment of early varicose in pregnancy |
| 18-24mmHg | Class II | B/K, T/L, men's socks | medium compression for varices of medium severity. Treatment of moderate oedema and varicosis during pregnancy. Post-sclerotherapy/-surgery. Prevention of recurrence of leg ulcers |
| 25-35mmHg | Class III | B/K, T/L | Strong compression for growth varicose veins, post-thrombotic venous insufficiency, gross oedema. For use with dressings in the treatment of leg ulcers and prevention of recurrence |

All garments should conform to British Standard BS6612

**Some 6.5 million people in the UK suffer each year with varicose veins, 5 million being women. Kimby Osbourne FLCH, Scholl training manager, takes a closer look at the condition and its treatment**

A varicose vein is one which is so dilated that its valves do not close to prevent backflow of blood. Such veins lose their elasticity, become elongated and torturous, and fibrous tissue replaces the tunic medias.

## The venous system

The venous system operates on three levels:

- the deep vein system
- the superficial veins
- the short perforating veins, which in the lower leg perforate the fascia, connecting deep and superficial systems.

The deep vein system carries 90 per cent of the blood that is returned to the heart, and, on contraction of the calf muscles, the veins contained within the fascia are squeezed. Valves at intervals along the inside of the vein ensure that blood can be squeezed in one direction only. The negative pressure within the deep veins sucks the 10 per cent of blood from the superficial veins via communicating veins.

Signs of problems can include: unsightly varicose veins; tired, aching, heavy legs; ankle swelling; irritation; eczema; night cramps; lipodermatosclerosis; superficial thrombophlebitis; and ulceration.

Varicose veins are usually thought to be a hereditary condition with causes including:

- insufficient number of valves within the veins
- weakness in the walls of the vessels.

## Predisposing factors

**Pregnancy**: pregnant women are particularly prone to develop varicose veins. During the early stages of pregnancy, the increased oestrogen levels cause the vein walls to relax and so dilate, while later in pregnancy this is further aggravated by the high blood flow in the pelvis.

**Obesity**: superficial veins in the limbs are supported by subcutaneous areolar tissue. Excess adipose tissue may not provide sufficient support.

**Constitutional**: any disease of the heart or lungs that may cause drastic changes in blood pressure is likely to have an important bearing on the development of varicose veins.

**Gravity**: standing for long periods with little muscle contraction tends to cause pooling of blood in the lower limbs and pelvis.

**Constriction**: any form of constriction, such as tight garters, self-supporting stockings, may press on the valve immediately below the constriction.

## Treatment

There are several ways of treating varicose veins and the method chosen by the doctor or vascular surgeon will depend on the age of the patient, state of health and degree of the condition.

- **Sclerotherapy (injections)** An injection of an irritant solution will be given into perforating veins which will set up an intense but controlled inflammation. The vein is then rendered ineffective.
- **Surgery (ligation and stripping)** Ligation is where an incision is made in the tissue at the ankle and groin, then the vein is tied off or 'ligated' at each end. It eventually withers. Stripping is similar to ligation, but at the stage where the vein has been tied, the vein is then removed or stripped from the leg completely. With both sclerotherapy and surgery, compression hosiery should always be continually worn.
- **Compression therapy (bandages and hosiery)**

The objective of compression therapy is to compress the superficial veins in the same way as the deep veins are compressed naturally by muscles, and apply graduated compression in the correct way to improve circulation.

The beneficial effects of compression hosiery include:

- increased tissue pressure
- decreased venous diameter
- shift of blood from the legs
- increased lymph flow
- increased fibrinolysis.

Support hosiery, available off prescription, offers less support than compression hosiery. Worn daily, they help prevent varicose veins.

## Measure and fit

To ensure correct fitting of graduated compression hosiery it is important to ensure correct measurement of the limbs are taken.

Over 90 per cent of patients fit into stock sizes, but for irregular limb dimensions made to measure stockings are available.

## Aftercare

To maintain the condition of support hosiery it is important to follow some basic care guidelines:

- hosiery should be hand-washed or 40°C machine-washed, using soap or mild detergents rinsing thoroughly
- dry flat away from direct heat
- finger nails and toe nails should be free from rough edges
- remove jewellery before putting on hosiery
- fitting socklets (for use with open toe hosiery only) can help, as can rubber gloves when putting on stockings.

## Final call for MCA course

It is with great reluctance that we have decided not to seek continued accreditation of our MCA training programme (*C&D* June 21, p18). Since its launch in 1989, it has led the field in counter assistant training and introduced the '2WHAM' questions.

The Royal Pharmaceutical Society requires that new assistants must commence an accredited course of training within three months of starting employment. The MCA course is based on a tutorial system where assistants are trained by community pharmacists in groups. It is impossible to guarantee that all assistants can commence training within the Society's three-month time limit.

The National Pharmaceutical Association and Radcliffe Medical Press urge assistants who start the course prior to August 31 to make every effort to complete it by the end of the year. We ask pharmacists to contact either us (01727 832161) or Radcliffe (01235 528820): we need to know which components of the course assistants still need to complete. We will then do our best to organise courses to meet the demand. Ideally we need this information by the end of July. No new students will be accepted onto the MCA training course after August 31.

**John D'Arcy**
*Director, National Pharmaceutical Association*

## Premature screening?

We noted your article on the Pharmacy Plus bone density screening service (*C&D* May 24). As chairman and director of the National Osteoporosis Society – the national organisation for supporting sufferers of osteoporosis and for promoting research into the condition – we are concerned that your article about the activities of the Osteoporosis Screening Service (OSS) is misleading.

The NOS feels it is important to improve both the diagnosis and early treatment and prevention of osteoporosis in a cost-effective way. Our council has considered the whole area of ultrasound diagnosis of osteoporosis, and we have published a position statement about the current situation. The summary of our report states:

- Quantitative Ultrasound (QUS) is a portable, quick and inexpensive method of bone mass assessment
- QUS cannot be used to diagnose osteoporosis and, at present, is unlikely to be helpful in assessing response to therapy
- Dual X-ray Absorptiometry (DXA) offers both diagnostic and monitoring capability, and is the current preferred method of assessment
- QUS appears to be an independent risk factor for hip fracture, but further research is required to assess its value in predicting other osteoporosis fractures, particularly in perimenopausal women and in men
- the role of ultrasound used as an indicator of the need for further risk assessment by DXA is urgently required
- given that there is only moderate correlation between different ultrasound machines, the results of specific studies cannot be applied to ultrasound in general.

We would like the pharmaceutical profession to be aware that the use of ultrasound to diagnose osteoporosis remains a research tool. The published scientific studies on the use of ultrasound to diagnose osteoporosis have included patients 75 years and older, and its value for screening women of 50 years and under is unproven. It is, therefore, premature to be offering an osteoporosis screening service based on ultrasound at the present time.

**Professor W Angus Wallace**
*Chairman, National Osteoporosis Society, head of Department of Orthopaedic & Accident Surgery, University of Nottingham*
**Linda Edwards**
*Director, National Osteoporosis Society*

## Tarred with the same brush

As a pharmacy representative, I take great exception to the generalisation in Mr El-Dabbagh's recent letter apropos to 'the pain of being visited by representatives of pharmaceutical companies'.

I'm sure there are some who conform to the description, but many of our number enjoy excellent relations with our customers, and take great pains to explain the relative merits, drawbacks and costings of the products in our brief.

Part of my job is to suffer pharmacists who refuse to afford me the opportunity to perform a valuable service for their business.

**Anon**

**Pharmacists face greater scrutiny because of Government initiatives to prevent NHS prescription fraud. David Reissner suggests that it is foolish to do anything that will arouse the wrong suspicions**

# Suspicious minds

Prescription fraud is in the public spotlight again after the recent publication of 'Prescription Fraud – An Efficiency Scrutiny', a report compiled by the NHS Executive that provides a detailed breakdown of how the prescription system is being manipulated by a few criminal doctors and pharmacists.

However, in fairness, the report does emphasise that most healthcare professionals are highly-committed and honest. But its findings, added to the Government's initiatives to crush the fraud, has created a highly-sensitive atmosphere.

Given the flexibility of the prescription system, it is easy to adopt, in good faith, working habits that could be misunderstood by the police or the fraud investigation unit of the Prescription Pricing Authority. The following tips should help you to nip potential suspicions in the bud:

- a business relationship with a doctor – for example, one which involves lending money or allowing credit – can easily be misunderstood, especially if financial transactions are not properly documented
- emergency supplies can legally be made without a prescription only if certain criteria are met, including record-keeping. It is not worth breaching the Medicines Act just to keep doctors happy. Pharmacists may occasionally feel the need to do this if a patient appears to be in need, but not on a systematic basis
- grasp the nettle and talk to a doctor about prescriptions which appear unusual
- do not sign exemption certificates for patients if you can possibly get them or their representatives to do it instead
- patients, not pharmacists, should generate requests for repeat prescriptions
- if all prescriptions are endorsed at the end of the month, you may not recall accurately what was actually supplied.

Occasional slip-ups, no matter how innocent your intentions, could have traumatic consequences, as the following case studies show.

## Case Study One

Pharmacist A was keen to expand his repeat prescription business. Patients often came in when they had run out or were on the point of running out of their medications. Pharmacist A held their repeat prescription cards. He would make a supply to patients, many of whom were exempt from prescription charges, and then ask the local surgery to provide prescriptions by sending the cards there.

When the prescriptions came in later, the patients were not around to sign the exemption certificates on the back. Pharmacist A signed them. In many cases, he signed by writing the name of the patient, rather than his own. A complaint from a patient with a grudge led to a police investigation.

The police asked patients if the signatures on the back of their prescriptions were genuinely theirs. In cases where Pharmacist A had signed their names, patients were asked if they had received the medication.

Many patients, having heard that someone had signed their names without their permission, concluded that if the signatures were not genuine they could not have received the medications prescribed.

Pharmacist A had been paid by the PPA for all the prescriptions. He was charged with obtaining money by deception.

By the time of his trial, his patients' medical records were available and it was possible to demonstrate to the patients that they must, after all, have received the medicines that were prescribed.

They accepted that Pharmacist A had occasionally supplied them with repeat medicines before a prescription was available. And they agreed that if they had not been supplied with the medicines which appeared on the questionable prescriptions, they would not have had enough to last them. The prosecution case collapsed on the third day of the trial, and Pharmacist A was acquitted.

However, the trial judge said that Pharmacist A had brought suspicion on himself and he refused to award him costs. Pharmacist A is now appealing to the European Court of Human Rights against the refusal of his costs.

## Case Study Two

When the police raided Pharmacist B's outlet, they found notepads listing medicines and prescriptions which they considered suspicious.

Pharmacist B explained to the police that patients were often sent to him by the surgery and told to request a particular medication and to say that the prescription would be forwarded direct to the pharmacy in due course.

Pharmacist B, after checking with the surgery, supplied the medicines before the prescriptions arrived. He sent lists of what he had dispensed to the surgery so that Dr O's receptionist could write out prescriptions for the doctor to sign.

Some of the prescriptions Pharmacist B received, however, often had more items than he had recorded in his lists.

A number of prescriptions did not seem genuine, such as those which had both a laxative and an anti-diarrhoea product, or those for unusually large quantities, or which appeared to be duplicated on the same day or within a few days.

Pharmacist B, Dr O and his receptionist were all charged

with conspiring to defraud the NHS.

Pharmacist B's defence team interviewed many patients, who explained that duplicate prescriptions occurred because, for example, the surgery had been asked for an additional supply of regular medication before the patient went on holiday. The easiest thing for the surgery to do was to push a button on the computer and produce a second, identical prescription.

It was apparent that the quantities prescribed on repeat prescriptions could be explained by Dr O's prescribing habits. What appeared to be inherent contradictions on prescriptions were the result of the time lapse between the supply of a product by Pharmacist B and the date, perhaps a month later, when the same patient wanted further medication. If Pharmacist B received the regular prescription later than usual, he would add it to the prescription dealing with the patient's extra request.

**Occasional slip-ups, no matter how innocent your intentions, could have traumatic consequences**

Prosecution witnesses who originally gave the police statements saying they had not received all the medicines on prescriptions written for them, told the court that they had received them after all. Their original statements to the police had been based on assumptions they, and the police, had made that the prescriptions were created for a fraudulent purpose.

In the event, none of the defendants had to call any witnesses because the prosecution case collapsed on the 38th and last day of the case for the Crown, when the prosecution found documents which ought to have been disclosed before the trial started. Pharmacist B, Dr O and his receptionist were all acquitted. Although the judge awarded them their costs, it was nevertheless at great personal cost to all three. If convicted, Pharmacist B and the other defendants would almost certainly have gone to prison. The case had hung over his head for three years.

*David Reissner is a partner at Charles Russell, a leading firm of solicitors, whose specialities include pharmacy issues.*

# Sign up for CiCPM and PMSI could pay your course fees

Marketing company PMSI will pay the £200 course fee for ten pharmacists who sign up for Part Two of the Certificate in Community Pharmacy Management, along with the £100 fee for 15 who sign up for Part One. This is provided they complete a questionnaire to be mailed to pharmacies in early July (details below). PMSI is pleased to support the Certificate in Community Pharmacy Management as it equips pharmacists to play a greater role in healthcare management


**Above: CiCPM Module Seven covers stock management and merchandising; renting and leasing. Look out for Module Eight in July's *Community Pharmacy***

The eighth module in Part One of the CiCPM qualification is published with the July issue of *Community Pharmacy*. Just complete all ten modules in Part One, plus the five projects in Part Two and you will have earned your CiCPM certificate.

The final Part One module will be published with September's *Community Pharmacy*

The five pharmacy-based projects will be sent to Part Two subscribers after every second Part One module has been completed. Modules are marked by our unique interactive telephone system, which provides formal evidence of your continuing education achievement for employers and professional bodies.

CiCPM is the first and only such qualification of its type for pharmacists and is designed to deliver the business skills omitted by traditional university pharmacy training.

If you choose to proceed to the full university certificate, then you will be among the first pharmacists with such recognised business expertise.

CiCPM is a ten-month course and you can start at anytime. If you join later, then you will simply qualify after autumn 1997.

SB PharmAssist Pharmacy Training Programme

## *Sign up now ...*

Full details of the CiCPM course are available from Sue Cheeseman on 01732 364422 and the registration form is published on page 23. The VAT-exclusive costs are:

- Part One: £100
- Part Two: £200
- Parts One and Two: £275

(if you register for both together).

The course is designed to be user-friendly and to deliver results for you and your business.

The CiCPM is part of Smithkline Beecham's PharmAssist programme and is supported by the company.

**WIN WITH PMSI**

# Get your fees back

Pharmacists signing up for either or both parts of the Certificate between March 1 and August 31, and who have filled out a questionnaire currently being sent out by PMSI are eligible for entry to a draw to be made at this year's Chemex exhibition (September 21). PMSI will reimburse Part Two course fees for ten qualifying pharmacists and 15 pharmacists' Part One course fees. (Fees should be initially paid to Miller Freeman.) The winners will be announced in October's *Community Pharmacy*.

Part One of the course comprises ten modules provided by Queen's University of Belfast, which are available through *Community Pharmacy* magazine. These, together with five pharmacy-based practical projects (Part Two), lead to the Certificate in Community Pharmacy Management.

# Manpower shortage alert

The shortage of pharmacists to fill community vacancies is continuing to cause concern at the National Pharmaceutical Association. Further investigation into the career choices of pharmacy graduates is needed urgently, the NPA Board decided last week.

A cross-section of members has indicated employers are continuing to experience problems with recruiting. An earlier Association survey, which examined the success of recruitment advertising, also suggested that companies were having trouble filling pharmacy manager posts.

As the number of registered pharmacists is increasing each year, it appears many are deciding against careers in the community.

The NPA strongly suspects that a significant factor is the relatively low salaries paid, a direct result of an underfunded pharmaceutical service. Other factors, such as the number of female pharmacists taking career breaks and longer opening hours, are also contributing.

The Royal Pharmaceutical Society said last year that it intended to carry out such research, but has not yet started. The NPA is to offer to collaborate with the Society in an attempt to get the research under way.

**Resale Price Maintenance and Competition Law reform** Chairman of the Community Pharmacy Action Group David Sharpe told the NPA the Office of Fair Trading is still some way off making an application to the Restrictive Practices Court for a review on RPM.

NPA director John D'Arcy and RPSGB secretary John Ferguson have met officials from the Department of Trade to discuss the new Competition Bill unveiled in the Queen's Speech. There is concern that new legislation in this area represents an additional threat to RPM.

**Baby milks** Anomalies over the supply of baby milks are to be drawn to the attention of the Department of Health. Its regulations allow health authorities to supply baby milks through clinics at, in many cases, a price below pharmacists' buying price.

The NPA says this practice is driving customers to buy from non-pharmacy outlets and wants the regulations to be altered to put milk prices on an even keel.

**New credit card handling rates** The NPA has renegotiated credit card handling rates for members with Midland Card Services. The new rates are 20p per transaction for Switch and Visa, a 2.25 per cent payment up to an annual credit card turnover of £20,000, a 2 per cent payment if the figure was between £20,000 and £75,000 and 1.72 per cent if more than £75,000. The terminal rental is unchanged at £5 per month.

**Script fraud** The NPA Board will prepare a response to the 100 recommendations made in the report on prescription fraud (*C&D* June 28, p4) at its July meeting. The Association will work with the DoH to improve the existing system, but will not advocate a policing role for pharmacists in preventing prescription fraud by patients.

**Primary care White Papers** The NPA is producing a summary of the provisions of the new Primary Care Act and the implications of the three White Papers issued towards the end of 1996.

**MCA Course** The College of Pharmacy Practice has withdrawn accreditation for the MCA course from August 31, following the decision by the NPA and Radcliffe Medical Press to discontinue it. Students are being encouraged to complete the course before the end of the year (**Letters,** p17).

**Parliamentary lobbying** The NPA has made contact with new ministers at the DoH. The minister for public health, Tessa Jowell, has been briefed on the role of the pharmacist in health promotion. Alan Milburn, the health minister with responsibility for pharmacy, has agreed to meet with the NPA. Members are being encouraged to lobby their local MPs.

# Reprimand for soon to retire pharmacist

A Staffordshire pharmacist, who left one of his shops in the care of unqualified staff, was reprimanded by the Royal Pharmaceutical Society's Statutory Committee last month.

Robert Browning, of Brereton Heath, Cheshire, appeared before the Committee in May last year after investigations revealed he had left his pharmacy in Newcastle-under-Lyme in the care of unqualified staff on at least four occasions.

Judgment was postponed for a year, with Committee chairman Gary Flather QC adding that Mr Browning should attempt to stay in touch with developments in his profession.

Last week, the Committee was told by Society inspector Jill Williams that, when she visited Mr Browning at his pharmacy in March this year, he hadn't attended any educational courses.

He told her of his intention to sell the pharmacy and saw no point in signing up for any courses. In addition, Mrs Williams said she had been informed by local police that Mr Browning had not co-operated with them following a number of burglaries at his premises.

Peter Rhodes, representing Mr Browning, told the hearing that there had been no further incidents of the sort which had led to last year's hearing.

Mr Browning had sold the pharmacy. He was also about to sell his second pharmacy in Stoke on Trent.

Mr Rhodes said his client had sent in his resignation last month. "He is a man who has given 30 years of service. He is highly-respected in the town where he lives and it would be unjust to strike him off the Register when he is so close to retirement."

Josselyn Hill, representing the Society, told the Committee that the RPSGB's rules did not allow a pharmacist to resign, only to retire so as not to continue paying fees. Mr Flather said it was possible that Mr Browning had offered his resignation in expectation of being struck off. If he was allowed to 'resign' at the end of June, there was nothing to stop him re-registering in July.

Mr Rhodes assured the Committee his client had no intention of doing so.

After delivering the Committee's decision to reprimand Mr Browning, Mr Flather said no penalty would be imposed on the company, B J Browning.

# PGEU goes Dutch for secretary general

The Pharmacy Group of the European Union, meeting last month in Bordeaux, has elected a new secretary general to replace the Belgian pharmacist Paul Baetens when he retires next year.

The new secretary, Lisette Diddens, a Dutch lobbyist, has previously occupied several posts, including one at the Royal Dutch Pharmaceutical Association.

The PGEU is continuing to reject the text of three draft documents which have been produced with other groups representing doctors and European OTC manufacturers.

The three texts are a common statement on self-medication, a self-medication leaflet for the public and a document advocating self-selection of non-prescription medicines.

The PGEU says they all undermine the role of the community pharmacist in self-medication and cannot be supported.

Collette McCreedy, secretary of the UK delegation, says the PGEU has received a report from the European Commission on the availability of medicines on the Internet, and the difficulties of controlling or outlawing availability from this source.

# Cromarty calls for clinical pharmacists for all

All patients should have access to the professional clinical services of a pharmacist within the NHS. And pharmacists should have access to clinical information on patients, who would be assured of confidentiality.

These were the views of Professor John Cromarty, national specialist in clinical pharmacy for Scotland, expressed in a public lecture at the Robert Gordon University, Aberdeen, on June 18.

He said: "The quality of patient care often suffers because of a failure in communication between healthcare professionals. The technology exists to ensure continuity of patient care. There is an urgent need now for the Government and healthcare professions to combine forces to deliver integrated care within the NHS."

Professor Cromarty is responsible for developing clinical pharmacy practice in hospitals and community pharmaceutical services throughout Scotland.

# 'What should I do?' in seven languages

A leaflet on common ailments has been issued in seven languages in the 'What should I do?' patient education programme.

Prices for the translated leaflets start at £410 for 500 leaflets (per language).

Interested pharmacists can obtain more information from RTFB Publishing, Building 2, Shamrock Quay, Southampton S014 5QL. Tel: 01703 229041.

# Wrongful supply of Controlled Drugs

A Barnet pharmacist, who gave a recovering addict supplies of Controlled Drugs without prescriptions, was reprimanded at a disciplinary hearing in June for serious misconduct.

Delivering the Statutory Committee's decision to Hitesh Kumar Premchand Shah, of Wilton Road, Barnet, chairman Gary Flather QC said the misconduct was serious enough to merit removal from the Register. But the Committee had taken into account the evidence before them. "You have to play Controlled Drugs by the book. Get it right this time," he said.

The charge of misconduct arose out of a police investigation last year, which revealed that Mr Shah had supplied his 'regular addict' with supplies of two Controlled Drugs on three occasions in January last year. He had also failed to record the supply in a register.

Mr Shah was subsequently convicted on four counts of failing to make entries in the Controlled Drugs register by Haringey Magistrates Court. He was given a conditional discharge.

Josselyn Hill, for the Society, said the incidents took place at Healthcare Chemist, Haringey, and were discovered after a police officer asked to see the CD register.

The register carried no entries made after the end of December, 1995, even though an addict, client A, was still coming to the pharmacy to collect the drugs. Mr Shah claimed that he was going to make the entries that day.

The policeman said Mr Shah had supplied the addict with the drugs that day, but when he asked to see the prescription, the pharmacist told him he did not have one. Mr Shah told him he had spoken to a doctor at the Haringey Drug Advisory Service (DASH), where client A was being treated, who told him to continue supplying client A.

Susan Beckett, a nurse at the clinic, told the Committee that she received a telephone call from the pharmacist on January 23 in which he said he had supplied Controlled Drugs to client A, but that he did not have a prescription. She told him that client A's treatment had ended on the previous day.

A team at DASH took the decision to extend the treatment by another week and got a locum doctor to sign the prescription on January 25, "because of the situation the chemist was in" said Ms Beckett.

Mr Shah denied that he had told the police officer that he had spoken to a doctor at the clinic. He added that he had called the clinic before he dispensed the drugs as he did not have the relevant prescription.

Client A was in his pharmacy and was becoming agitated at not receiving his supplies. It was only after he was reassured by Ms Beckett that he would receive the prescription that he dispensed the drugs.

David Reissner, representing Mr Shah, said he had dispensed the drugs only after speaking with Ms Beckett, but he was aware that "you cannot make emergency supplies of Controlled Drugs".

# Graduate's 'bad start to life in the profession'

A pre-registration pharmacy graduate, who lied about her work experience, found herself in front of the Royal Pharmaceutical Society's disciplinary committee last month.

Clara Ezed of Kennington, London, told the Society she had completed three months' training at St Thomas' Hospital's pharmacy when in she had been driving a mini bus for sick children.

After failing the registration exam in July and October, 1994, Ms Ezed was ordered to complete six months approved employment before sitting the exam a third time. She completed three months at Currans Pharmacy in Brixton up to January, 1995, but did not complete the second three months, and lied in a letter about the St Thomas' job.

The Statutory Committee has yet to decide if Ms Ezed, who successfully passed the registration exam at the third attempt, is fit to be included on the Register.

Her lie was quickly exposed when the Society wrote to St Thomas' and was told Ms Ezed had never worked in any of their pharmacies.

Committee chairman Gary Flather QC told Ms Ezed to return in a month with references. "At the moment, you are asking the Committee to make an assessment of you cold, without hearing from anybody else."

He told her: "It's a very bad start to life in the profession, but if you put it behind you, it will be the start of a new career."

# Pilot projects' flight to future

**Plans for pilot projects involving community pharmacists in repeat dispensing are well advanced. Adrienne de Mont discovers who is doing what**

Pilot projects are being set up or are already under way to test community pharmacy's role in repeat prescribing. Backed by £1 million Government funding, they have widely differing formats. In one group, pharmacists will issue repeat supplies of prescription medicines for a limited time or amount without further authorisation from the doctor. In another, pharmacists will assess the needs of specific patients, with a view to improving compliance and offering extra support.

The pilots aim to prove or disprove that community pharmacists have a valuable role to play in repeat prescribing, in terms of cutting the NHS drugs bill, improving patient care and saving doctors' time. The results are expected within 12-15 months.

Some of the trials are being evaluated locally with the help of universities. In addition, the Department of Health is setting up a central evaluation team, comprised of academics.

The largest project is a joint bid from the National Pharmaceutical Association and Pharmaceutical Services Negotiating Committee. They are collaborating with the University of York and the University of Aberdeen, whose evaluation team is the most experienced in repeat dispensing in the UK.

Pharmacist Christine Bond and her colleagues at Aberdeen's department of general practice and primary care have run a repeat dispensing scheme in the Grampian area, which is the biggest in the UK to date.

She says: "We have already shown there that pharmacist intervention in repeat prescribing has an added value." Pharmacists have identified adherence problems, adverse drug reactions and interactions, and made savings by not dispensing unnecessary items.

Other studies have been carried out in Tayside and Dorset.

Armed with this evidence, the NPA and PSNC persuaded the DoH the next logical step was to evaluate a large-scale pilot, based in different areas, and taking into account the lessons learned from previous trials.

## Joint project

**Joint NPA/PSNC/universities pilot**

The project will evaluate pharmacist intervention in repeat prescribing from the perspective of the patient and the involved professionals. It will also test three variables:

- if there is any difference when the pharmacist gets paid a proportion of the savings on the drugs bill as an incentive
- whether there is a difference if the prescription form is kept in the pharmacy or with the patient
- whether there is any difference between rural and urban areas.

The project will involve 5,000 patients from four health authorities – West Surrey, South Staffordshire, Shropshire and Sunderland – offering a range of urban and rural situations.

Pharmacists will not be asked to review formally the medication, but will use their patient medication records and an agreed protocol to assess if a repeat supply is needed. Patients will be given an information card explaining the system.

Although all pharmacists in the HAs will be able to take part, the NPA's Georgina Craig expects most patients will be seen by a relatively small proportion of pharmacies in each area.

**Procedure:** five GP practices per authority will each select 250 patients on long-term repeat medication, excluding those on Controlled Drugs, hormone replacement therapy, oral contraceptives or surgical supplies. Any patients who are due for a review in less than three months will also be excluded.

A tripartite prescription form is being designed with two carbon copies. The doctor writes the whole amount to be issued over three months on the top copy. The pharmacist dispenses the amount required in monthly instalments, sending one part of the form each month to the Prescription Pricing Authority, which reimburses the ingredient costs and a professional fee for patient consultation.

**Fee:** varying remuneration rates are being tested.

**Timing:** patients will be recruited in June and September, and should start presenting prescriptions in September. There will be a three-month intervention period, but the whole study lasts 15 months from beginning to end, including data analysis. Interim results are expected at the end of March next year and the full report in the August.

It should give the equivalent of 1,250 patient years' experience.

**Evaluation:** the project will be evaluated quantitatively by Professor Ian Russell and his team at the University of York's department of health sciences, who will look specifically at drug cost savings, health outcomes and convenience to patients.

Ms Bond, Catriona Matheson and their colleagues at Aberdeen University will evaluate the qualitative aspects, looking at the perceived quality of care and the experiences of patients, pharmacists and doctors.

Patients will be asked to complete a questionnaire. Pharmacists, GPs and their staff will be interviewed by telephone, as well as by questionnaire.

The evaluators, the NPA, PSNC and DoH, form part of a national steering committee for the project, which also includes GP representatives, the Patients Association, the Centre for Pharmacy Postgraduate Education and the Prescribing Support Unit. The chairman is Professor David Taylor, former assistant director, Audit Commission.

## Health Authority pilots

**1 Birmingham**

The study will evaluate the benefits, barriers and constraints to patients, pharmacists and GPs of patients being able to have repeat prescriptions dispensed without going to the surgery.

**Procedure:** seven pharmacies have been recruited centred around two GP practices. One surgery is in an inner-city area, the other in more affluent subur-

ban surroundings. The pharmacists and doctors will identify patients receiving regular repeat scripts. Patients will nominate a pharmacy of their choice. A prescription form is being designed, similar to that for dispensing Controlled Drugs in instalments.

**Fee:** as well as dispensing fees, the pharmacist will get an additional fee for completing the necessary paperwork and interviewing patients. The amount has yet to be decided.

**Timing:** patients are likely to be involved from August.

**Evaluation:** the project will be evaluated by Aston University's pharmacy practice unit and Birmingham and Solihull HAs.

**Contact:** Richard Seal (tel: 0121 333 4444, ext 2205).

### 2 Ealing, Hammersmith & Hounslow

The aim is to look at the acceptability, benefits and convenience of repeat dispensing for patients, pharmacists, GPs and the PPA. It will consider the time implications for GP staff, pharmacists and patients of this model of repeat dispensing, and assess its impact on patient care and spending on prescribed medication. It will also encompass starter and instalment dispensing.

**Procedure:** it is expected that ten GP practices will each recruit about 40 patients who will fit into one of two categories:

- those stabilised on continuous therapy, with five to eight particular drugs. Certain trigger drugs will be identified as likely to cause side-effects that might affect concordance
- those starting on new drugs who will need a small starter supply, followed by instalments.

The patients will not be restricted to one pharmacy. The GP will give up to six dated prescriptions which they can take to any pharmacy. The pharmacist will fill in an intervention questionnaire, checking for side-effects, for example, each time a repeat is requested.

**Fee:** pharmacists will receive the normal dispensing fee, plus an intervention fee for every questionnaire they complete.

**Timing:** it will be a 15-month project, which began in June, with a launch to patients expected around October. The prescriptions will be issued over about six months.

A steering group of pharmacists, GPs, plus representatives of the HA and patients, is being set up to decide protocols. Information packs will be prepared for pharmacists, GPs and the patients.

**Evaluation:** the project manager will evaluate the study on completion, liaising with the DoH evaluation team being set up to support the pilots.

**Project manager:** Sangeeta Sharma (tel: 0181 893 1303).

### 3 East Surrey

The aim is to assess the advantages and disadvantages to patients, pharmacists and GPs of pharmacists reviewing repeat prescriptions.

**Procedure:** four GP practices will recruit 200 patients who are taking more than three chronic medications. They will be asked to take their prescriptions to one pharmacy of their choice throughout the study. The project will run in a small part of the HA and involve three or four pharmacies in that locality.

The GPs will issue a tripartite prescription for a month's supply, with two monthly repeats. At the first repeat, the pharmacist will check adverse reactions. The prescription will be dispensed and ready to give out, but if the patient has problems, the pharmacist might contact the GP for further advice. If the patient does not come for the repeat within two days of it being due, the pharmacist will try to contact him or her. If there is no sign of the patient after seven days, the pharmacist will contact the GP. After the third dispensing, the pharmacist will carry out a full medication review and, if satisfied with the patient's condition, will request a prescription from the GP for another three months' supply or will refer the patient back to the GP for review.

**The pilots aim to prove community pharmacists have a role to play in repeat prescribing**

**Fee:** the pharmacist will receive medication review fees in addition to the normal dispensing fees. The amount has yet to be decided. The pharmacists will be given training for accreditation. Locum fees will be refunded if training is in working hours.

**Timing:** a pharmacist project manager is being recruited and a steering group set up. The project will run for 12 months and patients will be presenting the prescriptions for six months from this summer.

**Evaluation:** the project will be evaluated at the academic practice unit of St George's Hospital, London, and by the DoH evaluation unit. A report should be produced by March/April next year.

**Contact:** Gul Root (tel: 01372 731111).

### 4 Kensington, Chelsea & Westminster

This project is looking at instalment dispensing of three categories of medicines.

**Procedure:** participation will be open to all GPs and pharmacies (of which there are 150) covered by the HA. It will include a maximum of 200 patients. The GPs will decide which are entered, but the suggestion is for those on medication for tuberculosis, psychiatric conditions and those who need instalments for benzodiazepines and dihydrocodeine.

A special prescription form is being designed, similar to that used for methadone instalments, indicating at what intervals the medication should be dispensed, for a maximum 14 days' supply.

**Fee:** to be finalised, but the pharmacist will receive a fee for each instalment, possibly £1. There might be an allowance for supervising tuberculosis medication.

**Timing:** it will run for up to 12 months and patient participation will probably start in July.

**Evaluation:** the project will be assessed in conjunction with the central DoH evaluation team. The project manager will design an intervention form for the pharmacist to fill in data on how often the scheme is used, the intervention instalments, etc. She may also have access to some patients' notes to measure how effective tuberculosis medication was when supervised or given in instalments, compared with previously.

**Project manager:** Carol Wingate (tel: 0171 725 3402).

### 5 Sefton

This project will look specifically at dispensing for patients taking anti-depressants.

**Procedure:** about ten GPs and ten pharmacies are expected to take part, although it will be open to all. Patients will be asked to register with a pharmacy of their choice. They will be given an initial 14-day supply of medication, returning to the pharmacy after seven days. About 1,000 patients may be recruited. A steering group of researchers, including pharmacists, a GP and a public health consultant, have agreed protocols for the study. The main researcher is community pharmacist John Donohue.

**Fee:** the pharmacist will receive a fee of £30 for patient registration, as well as a dispensing fee and a further payment related to maintenance treatment.

**Timing:** the project runs for one year, with patient participation starting in August for six months.

**Evaluation:** this will be carried out by the HA's own team, but will comply with the national evaluation procedure.

**Project manager:** Alison Astles (tel: 0151 920 5056).

# Pharmacists under stress

Pharmacists need an occupational health service to help reduce their high stress levels, according to a stress specialist.

Dr Amanda Kirby, who conducted a stress survey of 200 pharmacists for Roche Consumer Health, says she was surprised by the levels she found.

One in two pharmacists suffer from tension headaches or backache due to stress. Fifty-nine per cent say they would not train to become a pharmacist in hindsight, because of their lifestyle.

Her survey also found that:

- 70 per cent say their paperwork increased last year, leaving them with less time to do other things
- 61 per cent say they sometimes feel too tired to concentrate on their jobs
- 60 per cent tended to get annoyed with other colleagues at the end of the day
- 55 per cent feel unprepared for the changing role of the community pharmacist
- 54 per cent say their families complain that they do not spend enough time with them
- 52 per cent have felt distress after a physical or verbally aggressive incident with a customer last year
- 48 per cent often feel resentment towards customers
- 48 per cent do not have the time to do things they consider important
- 44 per cent do not feel in control of their own schedule
- 41 per cent often feel resentment towards sales reps visiting their pharmacy
- 37 per cent did not take all the holiday they were entitled to last year
- 35 per cent have difficulty falling asleep at night.

Dr Kirby, who has studied stress in various professions, says the results mirror the comments she received from doctors when she questioned them about a year ago.

Pharmacists' resentment towards customers is a case in point. "This reflects what's happening in general doctors' practices. They're [the pharmacists] in the front line with patients' dissatisfaction about what's happening to them ... I don't think we're totally aware of what's going on," she says.

Change, she adds, is a typical contributor to stress. Pharmacists, like doctors, have been experiencing a lot of change in their working practices and have suffered as a result.

Dr Kirby was also surprised by the lack of holidays among her respondents. Major companies, she says, encourage employees to take holidays because they realise staff need time to recharge their batteries. Pharmacists being unable to take all their annual leave, for whatever reasons, is seen as a bad sign.

However, the pharmacists seem to realise the onus is on them to reduce their stress. Sixty per cent, for example, would talk to a colleague if they felt stressed, and 81 per cent would talk to a partner or spouse.

# Hills/Lloyds let go 17 in-store pharmacies

AAH/Lloyds is transferring 17 in-store pharmacies to supermarkets – 11 to Tesco and six to Sainsbury.

The in-store outlets, trading under Lloyds' name, were near the end of their leases. Michael Major, managing director of the group's retail division, says: "When acquiring Lloyds, we knew that these in-store pharmacies were in the process of disposal and had to revert [to the supermarkets' ownership] under the terms of their leases."

He adds that the number of stores involved is "very small and customers and nearby pharmacies will see no change".

# Budget for the future

Details of the Government's budget came too late for *C&D*'s deadlines. Its impact on community pharmacists and the pharmaceutical sector will be covered comprehensively in next week's issue.

# J R Butler's healthy stamp of approval

**Pharmacy manager Lee Karim, with director of JRBC, Mary Butler**

J R Butler Chemists in Reading, one of six pharmacies owned by the JRBC chain, has won an award for its health and safety procedures.

The outlet earned a bronze award after a Reading environmental health officer inspected it for ten health and safety regulations, including COSSH.

Reading Borough Council is one of only three local authorities in the country to run Healthy Business Awards, which comprise three levels: gold, silver and bronze. The silver award is given to firms with outstanding environmental or occupational health policies. Companies that satisfy the bronze and silver criteria are eligible for the gold award.

# SB loses appeal court battle over patents

Smithkline Beecham has lost its battle in the Appeal Court to prevent Norton Healthcare from revoking its patent on oral formulations of Augmentin.

Norton revoked the patent two years ago, but SB (then Beecham Group) disputed the move and took Norton to court. SB appealed after Norton won.

Last week, Lord Justice Aldous at the Appeal Court upheld the original decision.

SB says it is disappointed by the verdict, but that "it was not unexpected". It is seeking leave to lodge a further appeal before the House of Lords.

Norton has not produced its versions of the formulations during the legal battle, and seems unlikely to do so for a while as SB has an interlocutary injunction against the generic manufacturer and Lek, one of its suppliers, to prevent them from using SB's Diamine and Carbon Feeding Process patents (Lek needs these processes in order to produce the formulations).

Norton is fighting the injunction because it says SB is trying "to monopolise the sale of clavulanic acid [the formulations comprise a combination of amoxycillin and clavulanic acid] using patents which in Norton's view should never have been granted".

The case concerning the injunction is expected to be heard early next year.

- Norton has successfully challenged in the High Court three Riker/3M patents that would have prevented it from using P134A, a new ozone-friendly propellant, in its metered dose inhalers.

# 'Hospital pharmacists – a powerful force'

Hospital pharmacists are one of the most important customer groups in the UK pharmaceutical market, according to a report by Datamonitor.

The report, 'Customer paradigms: the new decision-makers', says hospital pharmacists have traditionally had more influence on drug usage than their community counterparts. It estimates there are 800 hospital pharmacies in the UK employing about 4,000 pharmacists.

These, it adds, have become more powerful because of hospital trusts. When a patient leaves a hospital, GPs tend to stick to the pharmacological treatment begun by the referring consultant. If a generic drug has been substituted for the original prescription, the hospital pharmacist would have chosen the product.

Most trusts also allow the hospital pharmacist to buy drugs for the hospital's formulary, which is drawn up in conjunction with its clinical directors and consultants. Hospital pharmacists may then be responsible for the trust's entire pharmaceutical budget.

The hospital pharmacist has little power over the prices at which drugs are sold to hospitals, but they are discounted at different rates depending on the pharmacist. The more significant the hospital formulary, the greater their bargaining power.

A product's inclusion on the hospital formulary can significantly lift its sales. Generally, trusts agree to buy products under contracts running from six months to one year.

The hospital pharmacist, according to Datamonitor, can therefore control the volume and value of a large part of the UK drug market. And that power is unlikely to change in the near future.

'Customer paradigms: the new decision-makers', price $2,995, Datamonitor, tel: 0171 625 8548.

# Amersham merges with Norwegian Nycomed

Amersham International plans to create one of the world's largest *in-vivo* diagnostic imaging agents by merging with Norwegian-based Nycomed.

This is Amersham's second major merger in consecutive months. Barely three weeks ago, it proposed to merge Amersham Life Science with Pharmacia Biotech to set up Amersham Pharmacia Biotech – the largest research-based biotechnology supplier in the world.

Amersham and Nycomed will be called Nycomed Amersham, whose combined worldwide imaging agent sales are expected to top $670 million.

Nycomed Amersham's market capitalisation is an estimated $1.8 billion. Taking into account Amersham Pharmacia Biotech, the new company would have operating profits of $244m on pro forma revenues of $1.5bn.

Nycomed Amersham also anticipates annual pre-tax cost savings of about $40m by 2001. Its annual research and development budget will be about the same.

Amersham comments that the merger makes a lot of sense because the companies have complementary interests – Amersham is a global leader in radiopharmaceuticals for the nuclear medicine industry, while Nycomed is a leading player in X-ray contrast media and magnetic resonance imaging.

Nycomed Amersham will also take advantage of NC100100, Nycomed's ultrasound agent that is expected to be submitted before the US Food and Drug Administration next year. Both companies say the agent could gain a significant share in the medium term of the growing ultrasound market, which could be worth $1bn by 2005.

The merger will be in the form of a share for share exchange. Nycomed's shareholders will be offered new shares in Amersham, representing 53 per cent of Nycomed Amersham's equity, and they will receive a special dividend of 16p for each Nycomed share.

Amersham's shareholders will own 47 per cent of Nycomed Amersham, which will be listed in London and is applying for listings in Oslo, New York and Copenhagen. Its headquarters will be in the UK.

Investors reacted positively to the deal. Amersham's shares in London rose 87.5p to 1,682.5p on Tuesday – the day the deal was announced – while Nycomed's shares grew 18 per cent to NKr131.5.

Its chairman will be Johan Fredrik Odfjell, currently chairman of Nycomed. Richard Lapthorne, Amersham's chairman, will be the new company's deputy chairman.

The merger is conditional on the formation of Amersham Pharmacia Biotech, and on the approval of Amersham's and Nycomed's shareholders.

## Rhone-Poulenc plans Ffr25bn restructure

Rhone-Poulenc intends to spend about Ffr25 billion to become the sole owner of US based Rhone Poulenc Rorer. The French company says the move will increase its pharmaceutical might – it is the 15th biggest drug company worldwide in terms of sales.

Rhone-Poulenc will pay RPR's minority shareholders $92 per share to lift its stake in the company from 68.3 to 100 per cent.

The French company will also combine its chemicals, and fibres and polymers businesses to create a new business that could be listed next year.

By effectively separating its pharmaceutical and chemical arms, Rhone-Poulenc says its market valuation should improve because its operating areas will be more clearly defined.

Rhone-Poulenc will cover pharmaceuticals, vaccines, and animal and plant health products.

The company's announcement pushed its shares up by Ffr10.60 to Ffr252.50 (19 per cent) on the Paris Bourse. RPR's shares in New York rose 11 per cent to $91.

Rhone-Poulenc intends to increase its equity by Ffr7bn to pay for part of the restructure. Its objective is to increase its earnings per share by 20 per cent this year and next.

## ML appoints new chief executive

ML Laboratories has promoted Stuart Sim, formerly deputy chief executive and finance director, to chief executive.

Kevin Leech, who was chairman and chief executive, is to concentrate solely on his responsibilities as executive chairman.

The company has also appointed Peter Shennan, formerly a principal at Coopers & Lybrand's corporate finance division, as finance director.

Its boardroom changes come as it prepares to register Icodial, its dialysis solution, in the US. The product has already been launched in the UK through Baxter Healthcare, MLs licensee. The company says the product's initial market penetration is higher than expected. A new Icodextrin plant to supply the active ingredient for Icodial has begun production.

Salbutamol Clic-haler and beclomethasone Clic-haler, both developed by ML and licensed under Medeva, are expected to be launched in the UK in autumn.

Products in the pipeline include D2S, an anti-viral agent for AIDS sufferers, which has begun Phase III trials.

ML is encouraging companies and people to take minority stakes in subsidiary companies it sets up to develop the products. If they wish, the company will buy back their stakes at a 'fair price' after the products have been launched.

ML reported a pre-tax profit of $2.89 million on a turnover of $4.56m for the six months to March 31. The latest profit comprises mainly access fees from licensees and an instalment from its settlement with Bespak.

## Shire Pharmaceuticals to market Urispas

Shire Pharmaceuticals has secured exclusive rights to distribute Urispas, an Italian treatment for urinary urgency, frequency and incontinence, in the UK, Ireland and 13 other countries.

Shire will handle the sales and marketing of Urispas, which is produced by Milan-based Recordati, and is negotiating to appoint distributors elsewhere.

The company is also recruiting a second sales force for its key products – it now has 31 brands.

Urispas has a 6 per cent share of the $17 million UK market for urinary urgency, frequency and incontinence products.

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### HUDDERSFIELD AREA

Retirement sale of sole village pharmacy trading from spacious leasehold premises occupying prominent corner site and fronting main crossroads. Projected T/O FYE 31 August 97 over £300,000, NHS items average 1,800 per month. Modest overheads and good real potential for more youthful proprietor. Offers around £65,000 for GW/Fix. SAV.

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* Source: Martin Hamblin readership survey.

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## PRODUCTS AND SERVICES





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**TRADE LESS 30%+VAT** - 1x50 Picolax, 2x100 Madopar caps 62.5, 2x100 Madopar disp 62.5, 1x100 Mycardol, 1x28 Flexin 75, 50 Baxan caps 500, 3x100 Sinemet Plus, 3 Trisequens forte, 27 Eldepryl 10mg, 24 Eucardic 12.5, 2x50 Elantan 40, plus others. Tel: 01849 452117.

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**TRADE LESS 30%+VAT** - 9 Suprefact vials, 1 Duovent, 28 Lederfen 450, 70 Megace 40mg, 30 Meptid 200mg, 56 Pertofran, 140 Probanthine, 64 Rifater, 44 Rimactane 300mg, Zinamide tabs, plus others. Tel: 0181-769 6692.

**TRADE LESS 30%+VAT** - 180 Sandimmun 25mg caps (exp 3/99), 49 Diflucan 50mg caps (exp 3/01), 12x20x2ml Atrovent 500mcg UDV (exp 6/99), 120 Megace 160mg tabs (exp 6/99). Tel: 01360 550242.

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**TRADE LESS 30%+VAT** - 21 Jevity 1ltr, 200 Zinamide, 67 Loron 520, 20 Fragmin 5000 inj, 6 Cyclo-Progynova 2mg, 100 Fentazin 4mg, Depixol inj (various). Tel: 0171 385 0355.

**TRADE LESS 25%+VAT** - 1x20

### EXCESS STOCK CAUTION

Pharmacists are responsible for the quality, safety and efficacy of medicines they supply. In purchasing from sources other than manufacturers or licensed wholesalers, they must satisfy themselves about product history, conditions of storage and so on.

# ABOUTpeople

## OBITUARY

Trevor Knights, general manager of Dendron, died suddenly at his home in Northwood, Middlesex, on Saturday, June 28.

*Dendron's chairman, Nigel Halsby, writes:* "Trevor was both a friend and a colleague. He was a born leader and he succeeded in helping everyone he worked with to achieve far more than they thought possible. His death at such an early stage is tragic and he will be missed greatly."

Trevor joined Dendron in 1991 from Gillette. In addition to his role as the company's general manager, he was also a director of the parent company, DDD.

A strategic thinker and a good organiser, his contribution to the company's business was considerable. During his six years there, he launched market-leading products such as Ibuleve, Bazuka Gel, Otex ear drops and Toepedo.

He leaves a wife, Linda, and two teenage children.

# Edinburgh Chemists' Golf Club centenary drives on

**The top table at the centenary dinner of the Edinburgh Chemists' Golf Club (l-r): SPGC chairman Andrew Taylor; Alan Cruikshank, chairman of the National Pharmaceutical Association; George Allan, centenary captain; Bill Harvey; guest speaker Dr J Douglas Stuart; honorary president Bernard Gallacher; and James Allan, centenary treasurer**

The highlight of the series of events marking the centenary of the Edinburgh Chemists' Golf Club took place last month when 48 players – members, guests and sponsors – played at Muirfield.

Following the golf, the players and another 70 guests enjoyed a centenary dinner at the Marine Hotel, North Berwick, in the company of the Club's honorary president Bernard Gallacher, the former Ryder Cup captain.

The oldest pharmaceutical golf club in the world was read a message from the Queen congratulating it on reaching such a milestone. Centenary captain George Allan presented Mr Gallacher with six reproduction pharmacy jars to mark the occasion.

Events still to come include matches against Glasgow and Lanarkshire Chemists, and a centenary ball at the Balmoral Hotel, Edinburgh, in November.

## APPOINTMENTS

**Alison Ewing** is new director of pharmacy services at the Countess of Chester Hospital.

**Tom Crimmins** has been appointed marketing manager of Roche Consumer Health. He replaces **Alan Main**, new OTC manager for South Africa.

AAH Pharmaceuticals has made **Christine Morris** Vantage communications manager.

IMS UK has appointed **Dr Philip Harrison** as medical R&D director.

Fujifilm Image Service has a new retail development executive, **Richard Harvey**, and marketing services manager, **Kate Walters**. **Julie Mawer** and business development manager **David Dickinson** have been promoted internally.

Eight of Scotland's 15 Health Boards have new chairmen. They are: Ayrshire & Arran, **Dr John Morrow**; Dumfries & Galloway, **John Ross**; Fife, **Charlotte Stenhouse**; Greater Glasgow, **Professor David Hamblen**; Highland, **Caroline Thompson**; Lothian, **Margaret Ford**; Shetland, **John Telford**; and Tayside, **Frances Havenga**. **Euan Bell-Scott**, Forth Valley, has had his interim appointment confirmed. The chairmen of the Borders, Lanarkshire, Orkney and Western Isles HBs have been re-appointed.

# Celebrating joint gold

Truro pharmacist John Hendra celebrated his golden wedding last month, while the business that he took over in 1947 celebrated its own golden anniversary. Joint celebrations included a party at the Falmouth Hotel attended by over 50 family and staff members.

The business, in Lower Lemon Street, Truro, was the place were he served his apprenticeship. He remains the managing director, but it is now run day to day by his son, Simon, who has worked there since qualifying in 1983.

It includes a hairdresser and health food outlet, and a section selling aids for the disabled is due to open later in the year after the outlet undergoes a refit.

John, now 82, qualified in 1938 and was made a fellow of the Pharmaceutical Society in 1970. He was an National Pharmaceutical Association Board member in the mid-1970s.

**John and Iris Hendra joined by family and long-serving employees at their golden wedding celebrations at the Falmouth Hotel last month**

# Straight from the horse's mouth

If you have connections, you might as well use them, and pharmacist Graham Jones did just that to ensure a celebrity was present at the official opening of the Shrivenham Pharmacy on Monday.

Mr Jones, who is superintendent of Thames Valley Chemists, which owns the business, also has a pharmacy in Lambourn. A regular customer is leading racehorse trainer Jenny Pitman, and she volunteered one of the more successful of her string, Garrison Savannah, for the task.

Fifty people turned out to watch the event. The horse was described as "frisky" by pharmacy manager Sally Wright.

The new outlet has opened in a rural area and was strongly opposed by the local dispensing doctor practice, which loses its dispensing list in 12 months time.


**Trainer Jenny Pitman (left) with Garrison Savannah, Graham Jones and Sally Wright outside the new Shrivenham Pharmacy**


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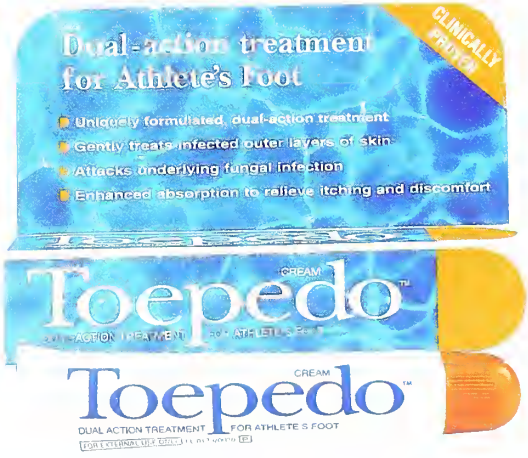


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TOEPEDO Trademark and Product Licence held by Diomed Developments Ltd., Hitchin, Herts, SG4 7DR, UK. Distributed by DDD Ltd, 94 Rickmansworth Road, Watford, Herts, WD1 7JJ, UK **Directions**: Apply a thin layer to the affected areas and massage gently until absorbed. Apply twice daily until symptoms clear. **Indications**: For the treatment and management of Athlete's Foot and other appropriate fungal skin infections. **Contra-indications**: Do not use to treat thrush and keep away from face, bottom and genital (sex) regions. Do not use on moles, rashes or any skin lesion for which TOEPEDO is not recommended. Do not use if sensitive to any of the ingredients. **Precautions**: Keep all medicines out of the reach of children. FOR EXTERNAL USE ONLY. **Side-effects:** Toepedo may occasionally cause mild skin irritation. **Legal Category**: P **Packing**: Tubes of 20g (PL0173/0020), RSP £3.95 (£3.36 exc. VAT). 5/97

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